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*The Third Dr. Murray S. Danforth Oration**

LOW BACK PAIN AND SCIATICA DUE TO LESIONS OF THE LUMBAR DISCS A STUDY OF THE RESULTS OF SURGICAL TREATMENT

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SINCE THIS LECTURESHIP was established in honor of Murray S. Danforth, A.B., M.D. (1879-1943), it seems to me very fitting that the subject should be low back pain and sciatica which he and I studied jointly beginning about 1921. It is difficult to look backward today and realize the heat of the controversy which raged at that time between those who believed that these symptoms were caused by disorders of the sacro-iliac joints and others who just as firmly claimed that they were due to disturbances in the lumbosacral region. Into this conflict moved Murray Danforth and the author naively hoping to carry out an investigation that would let the light of truth shine through.

Our paper was read at the meeting of the American Orthopedic Association in 1924 and was published the following year in the Journal of Bone and Joint Surgery.[1] From a series of anatomical dissections we showed the close relationship existing between the nerve roots of the lumbosacral plexus, and the various joint structures at the fourth and fifth lumbar level. We studied a group of 21 patients with these symptoms, all of whom showed positive neurological findings such as sensory loss in an area over one foot or leg, sometimes muscle weakness and frequently absence of the ankle reflex. We were unable to relate these clinical findings to the sacroiliac joint and concluded that there was actual pressure damage to the nerve root most frequently at the 5th lumbar, but also occasionally at the 4th lumbar due to pathological changes in the adjacent structures. We did not implicate the intervertebral disc because we did not find any examples of disc rupture in the cadavers studied, but we did trace the site of the lesion to the nerve root canal or to the point where the nerve root passed over the disc. This then was the forerunner for the later observation of disc herniation by Barr and Mixter.[2]

*Presented at Rhode Island Hospital, Providence, Rhode Island, December 3, 1959.

Conservative Treatment

The attitude of the modern orthopaedic surgeon towards low back pain is in favor of conservative treatment whenever possible. The more we follow surgical results in certain spinal cases the more we are impressed with the imperfections of operative treatment and the wisdom of finding ways to avoid operation when possible. The only conservative treatment that I know in patients with acute low back pain, or radiating pain down the leg is recumbency on a hard bed. Lateral, face prone and dorsal positions in bed are permitted, but not more than one pillow should be allowed under the head. The semi-reclining position should be prohibited. When in the dorsal position most patients are relieved by a pillow under the knees. I generally employ hot hydroculator packs to the low back because they are comforting. I don't feel that traction has any special efficacy, except that of keeping the restless patient quiet in bed. In general, patients are more comfortable when they can get along without it. I keep them in bed until the spinal list is eliminated and this usually requires two to three weeks and sometimes more. Under this regime I have seen pain and spasm abate, the range of straight leg raising increase and power return in the extensor muscles at the ankle which had previously been diminished.

When pain diminishes and the abnormal clinical signs become improved, it is time to begin a little activity with caution and on an increasing basis. I generally employ a simple brace of the Goldthwait type, or a supporting corset. Bending, lifting or carrying loads are prohibited. Activities are increased as the patient demonstrates his ability to tolerate them without recurrence of pain or spasm. When the patient is symptom free, I like to have them taught the Goldthwait system of exercises in the supine position. I think the patient should be followed carefully at monthly intervals until recovery is complete.

Barr stated in 1951[3] that "most observers agree that about 30% of disc lesions recovered completely after the first attack." Ytrehus[4] reported on 250 different cases with acute low back pain and sciatica who were treated by complete bed rest, the average

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period of hospitalization in these cases was 37 days and he reported 47% cured and free of symptoms on discharge. The examination two years later showed 34% were at full work and symptom free, while 37% were working but had some residual symptoms. Approximately 29% remained partially disabled. Friberg[5] stated that out of 20,000 patients examined at the Karolinska Institute in Stockholm who were complaining of pain in the low back, or leg, only 1,000 were subjected to operation or approximately 5%.

Case Studies at the Hospital for Special Surgery

At the Hospital for Special Surgery in New York, Doctors Roberto Moreira of Sao Paulo, Brazil and Robert Tate of Toronto, Canada, former Orthopaedic Research Fellows, have made a study of the results of the surgical treatment of low back pain and sciatica in patients treated between the years of 1941 and 1957, and I am borrowing extensively from their figures for this presentation. During this period 1,200 patients were admitted to the hospital with a diagnosis of herniation, extrusion or degeneration of the lumbar disc. Of these, 460 cases or 38.3% were subjected to operative treatment, while the remainder, comprising 740 patients or 61.7% were discharged home without operation following longer or shorter periods of conservative treatment. It must be remembered however, that this was a selected group of cases whose pain was so severe that they required hospitalization, and could not be cared for at home. During the same period many more patients were seen in the Out-patient Clinic or private offices by members of our staff without any recommendation for surgery or even hospital treatment.

Age and Sex

Among the surgical cases at Hospital for Special Surgery, there were nearly twice as many males as females, that is, 62.5% compared with 37.5%. The peak of incidence was between the ages of 35 and 40 years with a smaller peak between the ages of 45 and 50 years. Our experience shows however that pathological lesions of the lumbar disc were not confined to adult patients. This is demonstrated by 18 cases between the ages of 14 to 19 years. An analysis of these cases is shown in the following table.

TABLE I

Age	*Number of Patients*	*Type of Lesion*
14	1	Protrusion
15	1	Protrusion
16	3	Protrusion
18	7	Extrusions (2)
		Protrusions (5)
19	6	Extrusion (1)
		Protrusions (5)

In an analysis reported by Lars Unander-Scharin[6] of the occurrence of low back pain and sciatica among workers enrolled in the Sick Benefit Society of Stockholm, and in the Stockholm Tramway Company, it was shown that the most frequent incidence in men was between the ages of 40 and 60 and that in females over 39, the occurrence of these symptoms decreased.

Degeneration vs. Trauma

The onset of symptoms in our cases was gradual in 52% without history of antecedent trauma. Although there was a history of preceding trauma in many of our cases it was difficult to be sure whether this was only an aggravating factor or a causative factor. The duration of symptoms was over two years in 60% of our cases, and some patients gave histories of recurrent attacks dating back 45 years. The most common history was one of repeated attacks of low back pain with intervals of freedom from any symptoms. Previous attacks ranged from 2 to 20 or more. The most common pattern of pain was one of low back pain with Unilateral sciatica. (80%). Sometimes sciatica predominated over back pain or vice versa. Back pain with bilateral sciatic pain was present in 12.4%. Low back pain and gluteal pain alone were present in 6 cases or 1.3%.

Friberg and Hirsch[7] state that in a survey of persons ranging from 15 to 64 years in the Central Sick Benefit Society of Stockholm in 1948 complaints of low back pain or sciatica were found in 4.5% of all reported illness, with the peak of the complaints between 35 to 44 years.

Lars Unander-Scharin[6] made a study of the incidence of low back and sciatic pain among the traffic employees of the Stockholm Tramway Co., and the workers in other jobs who were enrolled in the Sick Benefit Society of Stockholm. He showed that it was 5.15% in the former and 2.475% in the latter or nearly twice as many. He thought this might be the result of the bouncing, jolting and rolling movements to which those working on the tramways were subjected and considered that this type of work caused greater strain of the spine than that resulting from the jobs in which the others were employed.

In another study made by Leonard Hult[8] in Sweden, comparing the occurrence of low back and sciatic pain among groups of forest workers with similar complaints among industrial workers it was shown that the symptoms of low back pain were first complained of at the age of 27.5 years in forest workers, and 29.5 years in industrial workers, whereas symptoms of sciatic radiating pain first appeared at the age of 34 years in forest workers and at the age of 35 and 2/3 years in the industrial workers. The industrial workers were working in a mill that produced hot drawn and cold drawn sheet iron, largely a machine operation, whereas the forest workers were chiefly engaged in cutting

trees and transporting lumber which incurred a heavy strain on the back. The figures on the incidence of symptoms in the two groups are so similar that one must conclude that the type of work made no difference. It is interesting to note that the low back complaints antedated the appearance of sciatic nerve symptoms by 7 to 8 years. Another interesting observation is that of the 276 industrial and forest workers that were studied 55% were incapacitated at some time by lumbago or sciatica. Of these 38% were disabled for approximately three weeks and 17% for more than three weeks.

Etiology of Disc Degeneration

In summary then except for isolated cases of traumatic rupture and protrusion of lumbar discs there is no clear proof that heavy work induces a higher incidence of low back pain than light work. On the other hand there is a great deal of evidence to show that degenerative changes in the intervertebral discs begin at a very early age and play an important role in the etiology.

Friberg and Hirsch[7] studied the spines of 100 cadavers and found disc degenerative changes present in 57% of the females and 43% of the males. The most common level of occurrence of these degenerative changes was the 4th lumbar space (47%) and next most common the 5th lumbar space (28%). In other words degenerative disc changes were found at the 4th or 5th lumbar spaces in 75% of the spines examined. They also showed that negative X-ray findings did not exclude the possibility of degeneration of the disc and that in some cases marked changes might be present without any X-ray changes. When the intervertebral disc space appeared narrowed by X-ray examination, they always found severe degenerative changes present. Friberg[5] considered disc herniation to be only one aspect of the whole problem.

The nucleus pulposus is a highly complex structure which Hirsch states is composed of water gel with an intricate pattern of connective tissue fibrils. Its chemical elements are protein, mucopolysachyrides and water. With increasing age the water content diminishes and the protein content increases. This seems to be a result of the decrease in the water binding capacity of the mucopolysachyrides with aging. The nucleus is surrounded by the annulus whose fibers are composed of fibrocartilage. There is no blood or nerve supply to the annulus. The fibers derive their nutrition from the tissue fluid that moves through the collagen fibrils and ground substance in a way that is not clearly understood. Nutrition is at its best in youth but decreases with aging and gradually a drying out process takes place with resultant loss of elasticity. The annulus fibers disintegrate and break. The points of greatest weakness seem always to develop toward the posterior surface of the disc leading from the center to the back on either side of the posterior longitudinal ligament. Finally complete rupture occurs and internal pressures cause fragments of the disc to protrude or herniate. Whatever the physical strain or spinal movement that takes place at the moment of rupture this is only the final increment, and disc protrusion could not have taken place unless there had been previous degeneration.

Because of the absence of nerve element in the disc fibers most of these changes take place without pain. There are pain fibers however running in the posterior ligaments[9] and these ligaments may be stretched or irritated from time to time by stresses caused by loss of elasticity in the annular fibers and resulting aberrations of movement of the vertebrae on each other. The symptoms produced by such stresses would be those of acute low back pain and the radiating pain down the leg would result from bulging or pressure of the disc material against the nerve root.

Positive Findings on Examination

Spinal Posture — A tilt or list of the spine was present in most of our cases. In 87% it was to the contralateral side from the sciatica. It was homolateral in 15.5% and in ten cases it was alternating, sometimes on one side and sometimes to the other.

Straight Leg Raising — There was limitation of straight leg raising in 90% of the cases. This was generally unilateral, but in 37% of the cases it was bilateral. This was the most common positive finding. Localized tenderness on local pressure or percussion over the lumbar discs was present in 84.4% of the cases.

Neurological Examination — Sensory disturbances with hypesthesia, paresthesia or analgesia were present in 49% of the patients. Disturbance of tendon reflexes was found in 63% of the patients; of these 84.7% were ankle reflex changes and 15.3% were knee reflex changes. We tried to correlate the level of the disc lesion found at operation with neurological findings, but we found the correlation very unreliable and inconclusive.

X-ray Examination — Abnormalities in the lumbar spine were found by X-ray examination in 51.4%. These abnormalities consisted either in narrowing of one of the lumbar disc spaces, or combinations of these changes. There was no instance of spondylolysis or spondylolisthesis in this series of cases.

Myelograms — We carried out myelographic examination in 173 or 37.8% of our cases. These were done almost entirely with Pantopaque. We feel that the decision as to whether surgical exploration is to be carried out must generally be based on the history and clinical findings. Since the large majority of lumbar disc herniations occur at either the fourth or fifth space (in our series 95%) we feel it is safer to explore both spaces almost routinely. Under these circumstances myelograms are unnecessary and only add an additional element of dis-

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comfort or risk. We reserve this procedure therefore, for special cases where there may be some question as to the advisability of operation, or a question of the exact level of herniation.

Of the 173 patients who had myelograms we eliminated 24 because they were not checked by operative findings. All of the other patients underwent operation and the exploration showed the following results:

Positive	115	(77.1%)
False Positives	20	(13.4%)
False Negatives	14	(9.5%)

In any discussion of the value of myelographic examination it is important to consider the different substances that may be used for visualization of the spinal canal. The first substance used was air but this gave poor visualization and the incidence of severe pressure headaches was high. Air was replaced by lipiodol which gave good definition of the spinal canal, but was viscid and difficult to withdraw completely after the examination. It was also thought to be somewhat irritating if left inside the thecal membranes. Then came pantopaque which was a lighter and less viscid substance and less irritating. This has been widely used in the last four years in the United States and in general the results have been satisfactory.

Little attention has been paid in this country to the development and use of a water soluble substance called Contrast U for myelographic examination. This drug which is somewhat similar to Skiodan has been used extensively in Sweden[10,11] and other European countries. It has the advantages of low specific gravity and low viscosity which allows it not only to delineate the spinal canal quite clearly but also to penetrate into the dural extensions along the spinal nerve roots as they emerge from the dural sack and to outline them clearly. The substance is absorbed by the vascular system and disappears completely in from 15 to 30 minutes.

Contrast U has the disadvantage of being slightly irritating to nerve tissue so that it causes a severe pain reaction. To counteract this it must be given under the cover of a low spinal anesthesia. The spinal anesthetic is introduced first and only after it has taken effect, generally after a lapse of 10 minutes, is the dose of Contrast U injected. The roentgenologist must work rapidly making a number of exposures with the patient's body in different degrees of rotation varying from the lateral to the prone position.

It is claimed that when properly carried out this method of myelography is harmless and that it yields more accurate information than with other methods. It is necessary however to limit its use to the lumbar area and prevent the material from flowing above the anesthetic zone. This eliminates it from use when a more extensive examination of the spinal canal is desired.

I may add that some of the medical staff of the Hospital for Special Surgery have been making a trial of this method and thus far have not had any unfavorable results.

Operative Findings — Of the 460 cases operated upon 379 or 81.5% had primary operations and 81 or 18.5% had secondary procedures. These latter patients were those who had been operated upon either elsewhere or in our own hospital without relief and in whom it was considered that additional surgery was indicated.

The operative findings revealed disc abnormalities in 402 cases or 82.6% and in 32 of the remainder or 7% there were soft bulging disc cartilages. Other abnormalities included meningioma 1 case, adenocarcinoma 1 case, and adhesion of the nerve roots 12 cases or 3%. In 12 or 3% there were completely negative findings with regards to disc pathology.

In cases of actual extrusion the fragments of disc material were removed and generally the disc space from which the disc had herniated was curetted. In the other conditions the disc cartilage was thoroughly curetted and the fragments removed making use of the pituitary forceps which is introduced many times systematically covering the 360° of the disc space. In 22 patients or 5% abnormalities of the disc were found at both L4-5 and L-5, S-1. Two cases showed positive findings at both L-3, L-4 and L-4, L-5 and one case was positive for the three lower disc spaces.

Spinal Fusion — Spinal fusion was performed in 107 patients or 23.3%. This was carried out as a primary procedure combined with disc exploration in 73 patients or 16% and in 34 or 7.3% it was carried out as a secondary procedure either as a late fusion or as a refusion. The technique of spinal fusion varied but in over half it was carried out in combination with internal fixation by a spinal plate. In 27 cases bone grafts from the bone bank were used, in 32 cases autogenous grafts were used, and in 8 cases no extraneous bone was used. The results were better with autogenous grafts and we now make little use of homogenous grafts in lumbar fusions.

Wound infection was reported in 18 cases or 3.9%. For the most part this was superficial and cleared up quickly. In cases with spinal fusion there was sometimes loss of grafted bone. There were no cases of infection of the disc space following exploration.

Follow-up Survey — We attempted to follow up by clinical examination as many of these patients as possible in order to find out the long-term end result of operative treatment. It was further hoped

to assess the relative merit of disc excision only as compared with excision plus fusion in the treatment of herniation of the lumbar nucleus pulposus.

The follow-up survey presented a considerable problem because it was conducted in 1958 and many of the patients had been operated upon from two to seventeen years previously. Furthermore, many of the patients came from distant points either in this country or in foreign countries. Letters were written to all of these patients asking them to return to the hospital for examination. 73 letters were returned marked "unknown", and six were reported dead. Twelve sent in letters stating they were unable to appear for one reason or another. Of the 310 patients therefore actually able to return, 147 did so, a return ratio close to 1 out of 2, which is considered good for the period of time elapsed. It was our impression that the patients returning probably represented a fair cross section of the end results obtained over the whole group. The shortest time interval since operation was two years, the longest seventeen years.

Evaluation of the results of the operation was rated in each case both from the standpoint of the patient, and also the surgeon. Evaluation from the standpoint of the patient was determined by his subjective response to the operation, that is, how he felt now as compared with how he felt prior to the procedure. Evaluation from the standpoint of the surgeon was determined by the objective findings at the end result examination based to a certain extent on the preoperative findings. The clinical reassessment of the patient was considered from the standpoint of the history, the physical examination and X-ray findings. X rays of the lumbosacral spine were taken in every case and films in flexion and extension were made in cases where spinal fusion had been done.

The methods of rating that were adopted are shown in the following Table:

Excellent: Patient very pleased with his result and able to return to and continue at his former or similar type of occupation. No pain since operation.

Good: No pain at the time of his examination. Minimal intermittent discomfort, not severe enough to interfere with pursuit of normal activities. Minor positive findings on examination, not normally distressing or disturbing to the patient.

Fair: Complaint of pain which might be constant or intermittent and which caused some slight limitation of normal activities. Positive findings on examination which were felt to be related to the pathological findings present prior to operation or thought to be the result of the surgical procedure carried out.

Poor A: Complaint of moderate or severe pain either constantly or intermittently whether present since the time of operation or a recurrence especially if felt to involve the previous level of protrusion or to be the result of the surgical procedure. Definite limitation of normal activities.

Poor B: Any obvious failure of a surgical procedure.

PROCEDURE CARRIED OUT ON THOSE RETURNING

Excision Only				*Combined Operation*			
M.	*F.*	*Total*	*%*	*M.*	*F.*	*Total*	*%*
71	38	109	*74.15	19	19	38	*25.85
			Single Level —	6	8	14	9.5
			Double Level —	13	10	23	15.7
			Multiple Level —	.....	1	1	0.7

Analysis of End Result

Excision only was carried out in 109 or 74.5% of 147 patients who returned for examination. These comprised 71 males, and 38 females.

Combined operation consisting of excision supplemented by spinal fusion was carried out in 38 or 25.5% of the patients who returned. These comprised 19 males, and 19 females. This represented one out of every four operated cases. In 14 or 9.5% the fusion involved one space only. Double level fusion was carried out in 23 patients or 15.7% of all procedures. 1 fusion extended from L-2 to the sacrum.

Length of Time Before Return to Normal Activity

Of the patients who underwent disc excision without fusion, 65 or 59.6% returned to normal activity inside of three months. In fact, many of these returned to normal activity in less than two months. In the patients however, who had undergone combined operations only 7 or 18.4% had returned to normal activity in three months, but 63.1% had returned to full activity inside of six months. Therefore, almost twice as long a period is

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Breakdown of Combined Operation from Standpoint of Patient Response

	Single level fusion		*Double level fusion*		*Multiple level fusion*	
	No.	*%*	*No.*	*%*	*No.*	*%*
Excellent	8	*57.15	13	*56.5	.....	.....
Good	5	*35.70	5	*21.7	1	100.0
Fair	1	7.15	4	17.4	.....	.....
Poor	.....	0.00	1	4.4	.....	.....

required for convalescence following combined operation as if excision only was practiced.

End Result Rating

The various ratings for the different procedures are shown in the table. Of the 109 patients upon whom disc excision alone was practiced, 72 or 66% obtained excellent or good results. Of the 38 patients upon whom combined operations were performed 32 or 84.2% obtained excellent or good results. There were 13.8% of the excision only group who were rated as poor results as compared to 2.6% of the combined operation group. Only three patients out of the 147 examined claimed they had no benefit following the operation. All of these were in the excision only group.

Complaints of paresthesia, numbness, cramps or weakness in some form or other were made in from about one-fourth to one-third the cases in both groups, these symptoms being about twice as common in the excision only group as in the combined operation group. A subsequent operation was necessary in five cases in the excision only group, an incidence of 4.5%. No subsequent operation was necessary in the combined group. Two of these later operations were performed for protrusions at a different level and would not seem to represent a failure of the first procedure. X-ray examination of the 38 cases with spinal fusion showed pseudarthrosis in 7. All of these developed in double level fusions. Only 2 out of the 7 had clinical signs or symptoms. The percentage instance of pseudarthrosis in this group was 18.4%.

Discussion

Consideration of the results of operative treatment of intervertebral disc lesions as shown in this study indicates that our present methods still fall far short of perfection and that there is a need for improvement.

From the standpoint of diagnosis we must still rely largely upon the history and clinical signs. Roentgen examination can be helpful in revealing structural abnormalities of the spine which must be considered in planning treatment but cannot be relied upon in judging the extent of changes in the discs. Narrowing of a disc is indicative of severe degenerative change but does not definitely point to that level as the point of herniation. In several cases of our series the disc protrusion was found at other levels.

Myelography is helpful but was unreliable in 23% of our cases. We should obtain more experience with the use of Contrast U as a contrast medium to find out if this method gives more accurate information. Perhaps some still better method of myelographic examination can be developed. This is a problem for the pharmacologists.

In cases where secondary operations are being considered and previous intraspinal operations have been performed myelographic examination is untrustworthy. Fibrous adhesions between the dural sac and neural sleeves can cause distortion of the myelogram so that it may become misleading.

In every series of disc operations that have been reported there have always appeared a number of cases in which no evidence of disc pathological change was found. In our own series this amounted to 12 cases or 3%. When the patient is operated upon with a diagnosis of disc herniation or protrusion and no lesion is found, this definitely represents misdiagnosis and we must ask the reason why. The more careful the search for a pathological disc the fewer the number of negative findings. We place a good deal of reliance upon the interdiscal fluid tension test in which salt solution is injected through a needle. The normal disc will take only 1-2 cc of salt solution whereas the degenerated disc will accept much more. This test is of considerable value in doubtful cases and may indicate a pathological condition that requires surgical treatment.

END RESULT RATING

	Over-all Rating				*Excision Only*				*Combined Operation*			
	Patient		*Doctor*		*Patient*		*Doctor*		*Patient*		*Doctor*	
	No.	*%*	*No.*	*%*	*No.*	*%*	*No.*	*%*	*No.*	*%*	*No.*	*%*
Excellent	57	*38.8	68	*46.3	36	*33.0	45	*41.3	21	*55.3	23	*60.5
Good	47	31.9	40	27.2	36	33.0	31	28.4	11	28.9	9	23.7
Fair	27	18.4	22	14.9	22	20.2	18	16.5	5	13.2	4	10.9
Poor	16	*10.9	17	11.6	15	*13.8	15	13.8	1	* 2.6	2	4.9

LENGTH OF TIME BEFORE RETURN TO NORMAL ACTIVITY

Excision Only					*Combined Operation*			
	M	*F*	*Total*	*%*	*M*	*F*	*Total*	*%*
Not yet	.....	5	5	4.6	1	.....	1	2.6
0 to 3 mos.	48	17	65	*59.6	3	4	7	18.4
3 to 6 mos.	17	11	28	25.7	8	9	17	*44.7
6 to 9 mos.	4	1	5	4.6	3	3	6	15.8
9 to 12 mos.	1	2	3	2.7	1	3	4	10.5
12 plus mos.	1	2	3	2.7	3	.....	3	7.9

The injection of a radio-opaque substance and an X-ray examination on the operating table might give additional confirmatory evidence of pathological change in the disc but is hardly necessary for the guidance of the surgeon.

It may be added here that spinal discograms have not been used in any of our cases as a method of diagnosis. This test can only confirm the presence of degenerative disc changes when present which the attending physician must already have suspected. It can not localize the lesion that is responsible for the symptoms nor can it really help in clarifying the operative indications. It may be added that few of the surgeons who pioneered with this method are still using it. This is because they found it gave little additional information that was helpful.

We must admit however that even after the most careful search for pathological changes in the discs there will always be a few with negative findings. I do not have any explanation for these cases. Perhaps the pain has been induced by changes in the spinal structures outside of the discs. The mere fact that some of the surgical explorations are negative should induce an attitude of the greatest caution in making a diagnosis of disc herniation or protrusion and advising operative treatment.

A few words may be added here about patients with psychoneurotic traits or anxiety neuroses who complain of low back pain or radiating pain in the leg. It is difficult to evaluate symptoms in these patients and the surgeon is apt to defer surgery for fear of disappointing results. Some of these patients have undergone previous spinal operations without relief. I have often obtained psychiatric consultation in such cases and have almost invariably received the same opinion which is to the effect that the patient has emotional problems and psychoneurotic tendencies but that these can only be treated after the cause of pain has been relieved. On the other hand I can recall a number of such patients, a few even with narcotic addiction who have been restored to normal or nearly normal lives by spinal surgery. I feel therefore that one must make as careful an evaluation as possible in such cases and that when there are operative indications one must go ahead and do the best job possible.

Finally, I want to express my opinion on the controversial subject of disc excision only versus combined operation with spinal fusion. In the patients whom we studied there was a higher proportion of excellent or good results among those who underwent the combined procedure than those in whom simple disc excision was performed. Also there was a lesser incidence of results that were rated poor and no secondary operations were required in these cases. Against this one must consider that the combined operation is much more severe than simple disc excision and that twice as long a time is required for recovery as compared with the latter.

While from the idealistic standpoint one might wish to supplement every disc excision by a spinal fusion one must be realistic and tailor each pattern according to the cloth, in other words fit the operation to the individual. My ideas may be illustrated by the following examples.

In the case of a healthy male under 50 years of age who wishes to lead an active life and who is suffering from discogenic symptoms, I would advise the combined procedure irrespective of positive or negative X-ray findings. In an older patient I would consult with him and try to work out a suitable program. In this case the finding of spinal abnormalities by X ray would color any opinion considerably.

When a patient is suffering from symptoms referable to an intervertebral disc lesion and the X-ray examination shows spinal abnormalities such as disc narrowing, erosion of apophyseal joints or disalignment of the vertebral bodies, I would recommend the combined operation.

Simple disc excision without fusion is indicated in women over 40 years and in patients of both sexes over 50 years when the symptoms are referable to nerve root irritation or pressure and complaints of previous low back pain are minimal.

Many patients can be recalled with other variations in age, symptoms and clinical findings, but the above will illustrate my belief in the necessity of approaching each as an individual problem and discussing the recommendations frankly with the patient.

The surgeon who advises spinal fusion as a supplement to disc excision has a great responsibility in ensuring that his operation accomplishes the desired result. In this connection I would emphasize the known fact that the incidence of pseudarthrosis is higher with two level than single level fusions. When we want to make our patients ambulatory at an early period in the post-operative period we should use a self-locking graft or some method of internal fixation such as the spinal plate or screws in the apophyseal joints. When extraneous bone transplantation is required we should use autogenous rather than homogenous bone for the best results.

CONCLUSIONS

1. The review of 460 operative cases and of follow-up results in 147 shows that the condition is more frequent among males than females and that the peak of the incidence is between 35 and 50 years.

2. The incidence of traumatic disc rupture is rare. All of the evidence points to degenerative changes in the discs as the underlying etiologic factor.

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COMMUNICABLE DISEASE CONTROL IN MODERN WAR*

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MY CONCEPT of modern war is one of action, directly aimed at the ability of a nation to produce—thereby reducing its ability to resist and retaliate. Wars no longer will be decided by armies on battlefields but, rather, by the resistance of the civilian population, their will to survive, and the maintenance of production in the face of attack. Obviously, therefore, industrial centers and the worker populations will have a priority as targets as high as retaliatory military bases.

Many weapon systems can and will be used, either singly or in combinations. These include hydrogen and atomic bombs, conventional explosives, fire bombs, chemicals, drugs and biological agents. They will be delivered from under the sea, by air and possibly from outer space as well as from the earth's surface. They can be delivered from great distances with remarkable accuracy and because of their great destructive power and wide fallout patterns a strike within a 5 to 10 mile radius of ground zero is considered on target. Furthermore, no real warning can be expected because of this ability to destroy at one time all or most of the important centers and bases and the fear of and the need to prevent retaliation. Finally, since these weapons can be employed covertly as well as overtly, the likelihood of sabotage can be safely predicted.

Whether the objective be destruction, area denial, killing or simply lowering the will of individuals and groups to resist, civil populations and industrial complexes will be involved because they represent productive capacity. Accordingly, there will be an extraordinary and formidable increase in health problems, both in number and kind. Among the most important of these will be the heightened opportunities for the spread and dissemination of disease agents of all types and varieties.

The need to consider and include plans for the control of communicable diseases, not only in wartime but in any kind of peacetime civilian disaster, can not be over-emphasized. They should be the present concern of all responsible authorities. While admitting the urgent necessity of adequate preparations for provision of casualty care and shelter against blast, fire and radiation, it is probable that these particular aspects of civil defense have been given far too much prominence. The ever-present problems of the control of disease, either naturally or artificially disseminated, have been relegated to a far too subordinate position in defense planning.

Utilizing the experiences of World War II, it is apparent and accepted that the danger of infectious disease will be not only increased by the widespread destruction possible in modern warfare, but will be magnified by the great probability of varying degrees and amounts of radiation exposure. Moreover, the deliberate dissemination or employment of biological agents would not be required to initiate and maintain outbreaks or epidemics. The breakdown of the carefully erected safeguards and peacetime protective measures and the many ever-present parasites will be quite sufficient. The numerous and varied disease control procedures work so well and so unobtrusively in modern civilization that most people have forgotten completely that they live in a sea of infection.

It is difficult to envision the magnitude of the medical problems as differentiated from directly related casualties, but it is obvious that the entire surviving population would be involved whether they are within or without strike areas. The increased rate of exposure to infection and disease would be the inevitable result of prolonged shelter life; later there would be a need for movement into and out of the damaged city as well as refugee camps and enforced billeting. Increased susceptibility may be safely predicted because of changed nutrition, enforced physical and mental strain, and similar war stresses. With the loss of facilities for water purification, sewage disposal, and the refrigeration and distribution of foods, there would be an increase in the opportunities for other animal and insect hosts and vectors to multiply and further to have better access to man.

There is need for the country as a whole to have an increased awareness and understanding of this

*Presented at the meeting of Military Government-Civil Affairs Public Health Society, at Atlantic City, New Jersey, October 19, 1959.

intensified disease risk in both peacetime and wartime disasters. This will demand more and better training of citizens and health workers, and of the medical profession itself. With the advent of antibiotics and other "miracle drugs," this specific aspect of medicine has been sadly neglected. As a matter of fact, even when this need is recognized, there are far too few chances to observe and study classical cases of the common infectious diseases in our modern civilizations.

Further defense planning for the control of communicable disease must take into account the obvious fact that there will be innumerable isolated communities and groups of varying size forced to live in a hostile environment, entirely restricted to and dependent upon immediate remaining local resources. Communication will be difficult or impossible and outside support available only after a considerable period of time has elapsed. It is also probable that there will be very little or no medical supervision or assistance. Accordingly, there is ample justification for the plea that a very high priority must be given to the dissemination of knowledge of disease dynamics and emergency control procedures required to maintain health and a safe environment.

In addition to other defense preparations in the health field, and in order to meet this specific situation, it has been recommended that:

(1) the individual citizen be trained to recognize at least some of the more common diseases and how to undertake a few important control measures;

(2) a ready reserve be created for health agencies by recruiting and training "health wardens" to assist in disease control efforts in all emergencies;

(3) present health resources be strengthened in terms of number of personnel, as well as training and in the provision of adequate facilities, diagnostic and therapeutic;

(4) more emphasis be placed on all aspects of preventive medicine in the curricula of medical, nursing and other professional schools;

(5) physicians be prepared for mass health problems as well as individual care.

In addition to these recommendations, it has been urged that:

(1) mass immunization campaigns, both primary and booster, be initiated for at least the ordinary communicable diseases;

(2) certain of the more unusual antigens be included in such programs, if possible, because of the predictable increased risk under disaster conditions;

(3) eradication programs, both for parasites and vectors, be seriously considered and undertaken now if thought feasible;

(4) facilities be organized, expanded, integrated and decentralized for the
   (a) diagnosis of infectious disease;
   (b) investigation of disease outbreaks;
   (c) institution of proper control procedures;

(5) the probable needs for hospitalization by individuals with medical problems, including infectious diseases, be considered in the planning of the emergency hospital services;

(6) an adequate, properly protected and quickly accessible stockpile of biologicals and drugs be developed and maintained.

It has been pointed out that a great need exists for much more, perhaps specifically oriented research in the field of infectious disease, such as:

(1) the effect of radiation, particularly multiple small doses and single exposures, on specific and nonspecific resistance to infection and disease;

(2) the influence of physical and mental stress on susceptibility to disease, especially considering the possibility that these factors may play a role in activating latent infections:

(3) the much needed improvement of single and multiple antigens, and mass immunization techniques.

Only a few of these proposals have been implemented, in part, in the United States.

Interest and deep concern is professed by all health workers about the many complex problems of communicable disease control in event of war. Usually the approach or attitude taken stems from or is influenced by World War II experiences. Although it is obvious that these cannot be accepted as satisfactory guide lines for modern war with the predictable far greater destruction and the inevitable and long periods of enforced crowded shelter life, a new line of attack has as yet to be evolved.

The Western European countries, like the United States, are in a sense trapped by the excellence of their present medical care programs. It is difficult to bring about changes in the dissemination of medical knowledge; to propose a "hospital corps man" level of medical care; to envision the planning and support of universal immunization campaigns with many antigens for an indefinite period. As a matter of fact, the most highly developed and industrialized countries are the most vulnerable. At the same time, they are the most reluctant to

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accept the necessity of this kind of planning and the proposals to lower the level of medical care.

Without precedents and forced to work with awesome estimates of the probable magnitude of the problem, perhaps this attitude is natural if not realistic. It is slowly changing, however, and while practical and reasonable plans must still be developed, the health agencies of all countries are beginning to look at health needs and disease control measures in modern war. They are recognizing at long last that, while casualty care may be the most immediate problem, in the long run the defenses that can be quickly raised against disease will become all-important in man's survival.

LOW BACK PAIN AND SCIATICA DUE TO LESIONS OF THE LUMBAR DISCS

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3. Degenerative changes may begin and become evident under the age of 20 years. In these cases one may postulate an accumulation of trauma in childhood as a cause.

4. The development of degenerative changes in the discs is insidious and often cannot be recognized on X-ray examination even when well advanced. Rupture or herniation of the disc is only a culminating incident in this cycle of changes.

5. From the study of operated cases and clinical experience it is concluded that conservative treatment should be followed until the complaints become excessive when operative treatment is indicated.

6. Spinal fusion supplemented disc excision in 107 or 23.3% of our 460 patients. Follow-up examination after 2 to 17 years was carried out in 147 patients of whom 38 or 25.5% had undergone spinal fusion.

7. Of the patients who underwent simple disc excision 66% obtained excellent or good results whereas among the patients who had undergone the combined procedure the results were excellent or good in 84.2%. The results were rated poor in 13.8% of the disc excision group compared with 2.6% of the combined operation group.

8. Twice as long a period of time is required for the rehabilitation of a patient following spinal fusion as following disc excision but the results are better and more permanent when spinal fusion is obtained.

9. The author advises that operative treatment of patients with symptoms due to disc degeneration or herniation be planned on an individual basis with due consideration of age, sex, history, clinical and X-ray findings.

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PATIENTS AND PROPRIETARY (PRIVATE) NURSING HOMES IN RHODE ISLAND, 1954

JOHN B. MITCHELL, ANNE THEINERT, AND GEORGE F. MOORE, JR.

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THIS ARTICLE REPORTS the characteristics of 908 persons, the patient population of 78 of Rhode Island's 79 proprietary nursing homes in operation during 1954.[1] The primary diagnosis of chronic conditions and the age and sex composition of this population are reported. These data also provide information on the physical condition of patients. The number and training of persons providing nursing and other services and cost of these services are discussed. The final section considers the location of homes and their occupancy rates. This information can serve as a bench mark for future studies of Rhode Island's nursing homes.

Rhode Island was one of thirteen states co-operating with the National Commission on Chronic Illness in a study of nursing homes.[2] Schedules and instructions devised by the Commission on Chronic Illness were used in this study.

As could be expected, the vast majority of patients were in the upper age brackets. Two of every three patients were 75 years of age or older. The average age of patients was 78. A number of trends, such as advances in medical knowledge and increase in life expectancy, would indicate that average age of patients may be 80 or over in a few years.

TABLE I
Age of Proprietary (Private) Nursing Home Patients by Sex, Rhode Island, 1954

Age	*Total*		*Males*		*Females*	
	No.	*%*	*No.*	*%*	*No.*	*%*
TOTAL	908	100.0	232	100.0	676	100.0
Less than 65	79	8.7	35	15.1	44	6.5
65-74	214	23.6	53	22.8	161	23.8
75 & over	595	65.5	140	60.4	455	67.3
Unknown	20	2.2	4	1.7	16	2.4

No attempt was made to consider characteristics of this population by race for only six non-white patients were reported.

Women outnumbered men by almost three to one. Females made up 74.4% of the patient population. The average age by sex was 76 for males and 79.3 for females. This age difference by sex was reflected in the amount of care needed by male and female residents of nursing homes. Female patients required more services and greater frequency of services than male patients.

Chronic diseases or disabilities were almost universal in this population. Eight hundred and eighty-four patients (97.3%) had one or more chronic conditions that contributed to their need for care in a nursing home. Only primary diagnoses are shown in Table II although a majority of the patients had a secondary condition which contributed to their disability. However, 384 patients (42.3%) had not been examined by a physician or visited a clinic within the thirty days preceding the survey. This may raise questions as to the extent of physician services for nursing home patients.

Cardiovascular conditions which include heart disease, hemiplegia, and other circulatory diseases, were reported most frequently as the primary diagnosis of a chronic condition. Approximately four of every ten patients had a circulatory disease.

TABLE II
Primary Diagnoses of Chronic Conditions Reported for Patients in Rhode Island Proprietary Nursing Homes, 1954

Diagnosis	*Primary Diagnoses*	
	No.	*%*
TOTAL PATIENTS	908	100.0
Cardiovascular	353	38.9
Senility	162	17.8
Fractures (hip and others)	92	10.1
Arthritis and Rheumatism	62	6.8
All other	215	23.7
No Diagnosis	24	2.7

Heart disease and hemiplegia resulting from stroke were disabilities reported most frequently in the cardiovascular category. Senility and fracture, mostly of the hip, ranked second and third in terms of primary diagnosis. These findings coincide with data from nine other states. Cardiovascular diseases, followed by senility and fractures, led all other diseases as the primary condition contributing to a person's need for nursing home care.[3]

These conditions, plus other primary and secondary diseases, reduce the physical and mental facilities of the patient population. One hundred and seventy (18.7%) remained in bed all of the time. An additional 305 (33.6%) were in bed part or most of the time (other than to sleep or rest). Only 411 (45.3%) could walk about unassisted.

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Five hundred and six (55.7%) of the patients were "mentally confused" part or most of the time. They were forgetful and found it difficult to remember events and day-to-day activities. Other state studies report approximately this same percentage of patients mentally confused.[4] In addition, 301 patients in this population were unable to control the functions of their bowels or bladder or both.

These physical and mental conditions call for a variety of nursing and personal services. Medication of some sort was the most frequent type of nursing service provided by the staff. Other nursing services include full bed baths, enemas, hypodermic injections and dressings. In addition, 274 patients were on special diets. A *salt-free* or *low-salt* diet was the most commonly prescribed type of diet.

The 78 homes employed 576 persons to provide nursing and other services for this patient population. Of this number, 146 worked on a part-time basis.* The skill of these persons ranged from licensed graduate nurses to attendants with little formal training. Personnel were classified according to their skill-level and their distribution is show in Table III.

TABLE III
Staff of Rhode Island Proprietary Nursing Homes by Skill Level, 1954

Skill Level	*Staff* No.	*Staff* %
TOTAL	503	100.0
Licensed graduate nurse	60	12.0
Licensed practical nurse	141	28.0
Other nursing staff	160	31.8
All others	142	28.2

Thirty-nine establishments employed one or more licensed graduate nurses on a full or part-time basis. However, variations in the distribution of graduate nurses by bed-size of homes were evident. Only one of every three establishments (32.1%) with less than ten beds employed a licensed graduate nurse. One of every two homes (52.0%) in the 10-14 bed size group reported a graduate nurse. Two of every three (68.0%) of the larger homes employed one or more registered nurses. The proportion of nursing homes employing licensed graduate nurses increased with the size of the establishment.

*The 146 part-time personnel were arbitrarily considered to work one-half time. This accounts for the total of 503 in Table III.

The median monthly charge per patient was $169.00. One of every two patients (51.3%), or the patient's family, paid the entire cost of nursing home care. Public welfare funds paid for all or part of the expenses in more than 50% of the cases in six other states.[5] Only California, in the nine state study, reported a higher monthly charge, $195.00. However, California was the only state with the same patient/staff ratio, 1.8. All other states had higher ratios — more patients per staff member. Also, only Vermont had a slightly higher percentage of total staff who were licensed graduate nurses, 12.1% as compared to 12.0% for Rhode Island. The percentage of licensed practical nurses in Rhode Island (28.0%) also exceed that of the other states. New York (upstate only) with 24.0% of total staff being licensed practical nurses was the only one to approach Rhode Island's percentage.[6]

On the basis of these data, one may conclude that, although the median monthly charge of Rhode Island homes exceeds that of eight other states, the quality of the care and the attendant time per patient exceeds that of nursing homes in these states. Rhode Island is out in front when skill-level of staff and patient/staff ratios are compared with similar data from other states. The writers are aware that these criteria do not include all the factors which influence the effectiveness of nursing home personnel.

The distribution of the 78 homes by bed size and their patient population is shown in Table IV. The 25 larger homes provided more than one half of the beds and housed 55.6% of the patients. However, the establishments shared the patient populations almost equally when distribution of patients was considered on a bed capacity basis. There was only a slight variation in average daily census by size.

Fifty of these establishments, almost two of every three (64%), were located in Providence County. Newport County reported ten homes, Washington eight, Kent seven, and Bristol three.

As the number of aged increase in Rhode Island and in most other states, chronic illnesses and their attendant long term need for care will place greater demands on health personnel and facilities. Nurs-

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TABLE IV
Proprietary (Private) Nursing Homes by Bed Size, Number of Patients, and Per Cent of Beds Occupied, Rhode Island, 1954

Size of Home By Beds	*Homes* No.	*Homes* %	*Beds* No.	*Beds* %	*Patients* No.	*Patients* %	*% of Beds Occupied*
TOTAL	78	100.0	1,107	100.0	908	100.0	82.0
Under 10	28	36.0	175	15.8	141	15.5	80.6
10 - 14	25	32.0	301	27.2	262	28.9	87.0
15 & over	25	32.0	631	57.0	505	55.6	80.0

PHYSICIANS SERVICE IN 1959

Report of the *President,* CHARLES J. ASHWORTH, M.D., at the Eleventh Annual Meeting of the Corporation of the Rhode Island Medical Society Physicians Service on January 25, 1960

THIS YEAR, 1959, has seen an extension of our efforts to keep pace with the rapidly changing pattern of medicine's reaction and responsibility to the demands of an era that we did not contemplate, invite, or encourage. Nevertheless, one cannot escape the fact that the last twelve months have recorded a much greater challenge to Physicians Service than was envisioned a year ago.

Great accomplishment can be filed in the area of progress. After lengthy deliberation, our medical society's committees evolved a fee schedule that the board of directors was able to approve with an income ceiling of your choice after untold hours of figuring and fashioning by the administrative staff of actuaries and administrators.

Our "B" Plan resulted. The sale of this $5,500, $4,500 — $3,500 income limit with a fee schedule that jumped from a top of $225 to a maximum of $400 was launched, and to date has already been purchased by companies with a total subscriber list exceeding 60,000. Its initial success bids fair to continue.

The financial details of our operation in 1959 have been presented in the treasurer's report. I cannot refrain, however, from pointing out again that the financial statement reflects a deficit in the operation of the Plan for the first time in our ten years of operation and marks our progress this year as something less than 100%. The deficit occurred in Plan "A," not in our new Plan "B."

One may ask WHY? Your board of directors, fortified by figures and accurate predictions, authorized a program of defense against this anticipated deficit which took the form in the year 1959 of a carefully planned series of meetings with the various county societies and some hospital staffs, at which the problem was presented and some suggestions offered that might lessen, if not avert, the end point at which we finally arrived. Reiteration of those points would be repetitious in this report. The all important impact, however, lies in the fact that with our "B" Plan now in operation, this year of 1960 cannot be contained within the limits of present income. Careful consideration to this problem must be given by us all, individually and collectively.

Lest anyone might think that the board, alerted to this possibility did not take measures to correct it, may I review some of the measures employed toward this end. Three areas of service to our subscribers immediately stood out as targets against which to enlist our efforts:

1. Overuse of X-ray benefits.
2. Small inconsequential surgical procedures done in the office.
3. Prolonged questionably hospital stays.

The committees of your board of directors have not only done yeomen work on these assignments, but we know that much success has been achieved. There will be no relaxation this coming year, but rather intensified efforts to keep the profession as well as the public alerted to these safeguards against overuse and, in some instances, abuse of the Plan.

Careful planning by the board and its committees has taken cognizance of the many suggestions made at the meetings held last year. Throughout these coming months, your individual checks will be accompanied by a brief but concise pamphlet, two of which have already been mailed, commenting upon the Plan. May I urge you to give these monthly briefs the few minutes they deserve in order to keep you informed about the status of your Plan and your obligation as members of this corporation to be informed and able to discuss it in the light of such threats as the Forand type of legislation, increased costs, and additional benefits and demands. It is an individual responsibility that no one can disregard.

The development of an effective and efficient utilization committee suggested by our Board of Directors and patterned after the Pennsylvania Medical Society's committee, now being implemented by the Rhode Island Medical Society, Rhode Island Hospital Association, and Blue Cross, will be an achievement to be anticipated this year. I, personally, am confident of its success.

Permit me to recall to your attention a warning in my report of one year ago that emphasized the narrow margin of less than $150,000 by which we concluded 1958, and again predict that with your help and careful attention to the minor as well as major details of our Plan's operation, we hope to reduce our losses. That will be our contribution locally, at least, to the 1960 national effort not only

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against further inflation, but toward a reduction in the present inflated economy.

The immediate future poses two trying problems for resolution and decision:

1. Making the necessary adjustments to be eligible for participation in the coverage of employees in the national government which may ultimately be enhanced by membership in Blue Shield.
2. Completion of our previous plans for providing extended coverage over and above our basic coverages now available in Plans "A" and "B."

At this point, gentlemen, may I say that it is by sincere intent, but with arduous restraint, this report will be concluded briefly in order that we will not encroach upon the time of our guest speaker an innovation at this meeting that I am sure will not only be rewarding but much more informative than further exhortations on my part to remind you that each year of Physicians Service further involves our individual responsibility to maintain in continuity a record of success.

This report I render tonight, as in the past, always, in my humble opinion, reflects a deficiency in the category of expressed gratitude but, on this particular occasion, permit me to be a bit superlative in the praise of and thanks to our executive director, Stanley H. Saunders, and his staff, including Edgar H. Clapp, associate director, Arthur Hanley, J. Lewis Eddy, and George Peterson. They merit a special word of recognition for maintaining a high in public relations. The entire administrative staff is not to be omitted from our wholehearted appreciation of their effort and efficiency.

Permit me also to express upon your behalf this annual word of gracious recognition especially to the laymen on our board, as well as the doctor members for their devoted sacrifices to the professional and public interests of Physicians Service. Finally, a word of thanks to you members of this corporation, from your board, for the continued support and encouragement reflected by your record of approval for endeavors devoted to the best interests of all concerned.

I sincerely hope that record will be continued, particularly by maintaining the high caliber of personnel on your board that has served you so well.

The apathy of a generation ago has been replaced by a united and dedicated action on our part to preserve a free competitive enterprise system with an ever-increasing resistance to federal encroachment in the field of health care. Only continued vigilance against further assaults upon this basic concept of the American way of life, we know, can protect the public and ourselves against the bounteous benefits so subtly offered in a planned economy, the apparent generosity of which is derived only from your dollar and mine.

Physicians Service, then, continues to be one of the best plans of its kind in the entire country. This has been pointed out on previous occasions, but the emphasis I want to give it warrants repetition.

1. It has the highest percentage of population covered of any plan in the United States.
2. It has the lowest operating cost of any plan.

These evidences of the fact that it is one of the best plans, you must agree, deny contradiction. Let us try to keep it one of the best plans in the country by adjusting to the changes as they develop and implementing the plan in those areas that will keep it on its present high level of success in the nation.

Confidence, then, is the note upon which this report concludes. In the words of an old Roman, *Confidence, like the soul, never returns whence it has once departed.*

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ing homes adequately staffed help provide facilities for the chronically ill whose conditions do not require hospitalization.

REFERENCES

[1]Velma Fitzgerald, Mrs. Irene Paquette, Mrs. Ester Harlow and Mrs. Nettie Farrell, assisted Mrs. Anne Theinert in collecting these data. Miss Hazel Hopkins, State Department of Social Welfare also participated in the study

[2]Colorado, Connecticut, and Georgia have made similar studies. A summary of proprietary nursing home studies from California, Indiana, Maryland, Minnesota, New Mexico, New York (Upstate), Oklahoma, Vermont, and Wyoming is contained in an article by Jerry Solon and Dean W. Roberts, "Survey Shows How Services Vary," *The Modern Hospital*, 84:67-74, May, 1955

[3]Jerry Solon and Dean W. Roberts, "Survey Shows How Services Vary," *The Modern Hospital*, 84:69, May, 1955

[4]*Ibid.*, p. 70

[5]*Ibid.*, p. 72

[6]*Ibid.*, p. 73

Editorials

EMOTIONALISM

"There is one art of which every man should be master — the art of reflection" COLERIDGE

THE NEWS HEADLINE read "Vets Hospital Unnecessary, Rhode Island Medical Group Reports."

The news story stated that the small proportion of patients with service-connected disabilities at the Veterans Administration Hospital in Providence could easily be absorbed at the Newport Naval Hospital and the Quonset Dispensary, according to a report approved by the House of Delegates of the Rhode Island Medical Society.

The newspaper also stated that the Society's report indicated that if the government installations were utilized, and the other patients transferred to other general hospitals, the VA facility "would be unnecessary and the taxpayers would be saved a tremendous amount of money." The news account also reported that the Society acknowledged that this proposal may not be politically expedient, and therefore it urged as an immediate goal the tightening of regulations for admission to VA hospitals in order to place more emphasis on financial need.

The Society was immediately made the target of abuse by veterans organizations and labor groups for its audacity to suggest that the taxpayers of this country take a second look at the cost of the veterans hospital system, and that the veteran with a non-service-connected disability be more carefully screened for admission to free care at the expense of the general public.

Why the flood of emotional outbursts by men who are supposed to be leaders of organizations that have recognized standing in our communities? How many of these leaders took the time to find out what the complete report of the Society presented? How many can refute the facts presented in the report?

Why does a member of the General Assembly call for unanimous action on his resolution to resist all efforts by the Society to effect a closing or tightening of regulations at the VA hospital when he hasn't even read the report or informed himself of the facts presented in it?

Why does a leader of an outstanding veterans organization deliver a public tirade of abuse of physicians — most of whom are veterans, too, and with records of service in combat areas — and say nothing about the basic issue raised in the Society's report?

Why do other veterans' organization leaders denounce the report when they have not read it? How can they challenge the sincerity of it, and why do they beg the question by raising irrelevant questions alout medical and hospital care in general?

Why do the equally uninformed labor spokesmen criticize doctors for speaking as taxpayers when their own labor publication at the same time editorially states to the Rhode Island people that "Unless Americans, acting jointly, exert a restraining influence on government, the country's security and financial stability is definitely endangered in the sixties by the possibility of a continuation of fiscal policies followed in the 1950's?"

Why does the Council in our largest city vote opposition to a report it has not read, with only one Councillor calling attention to the lack of knowledge of the Society's report and citing the Council's impetuous action as bordering on the "foolish?"

Have our community organization leaders become victims of the headline writer, slaves to the news summary which all too often provides insufficient information for sound reflection on major issues? Have our leaders completely lost contact with the art of reflection which in turn calls for complete understanding of the subject to be considered?

Without reflection on controversial issues, prejudice, the child of ignorance, grows to full maturity, sense gives way to nonsense, and reason veils her face.

CYTOLOGY PROJECT ENDS

On April 1 the Rhode Island Women's Cytology Program will terminate with a record of successful achievement. The objectives sought and accomplished by the program have been to determine the incidence of clinically unsuspected carcinoma of the cervix, to train technologists to examine cytology smears (Papanicalaou), to demonstrate to physicians the value of this procedure as part of the routine physical examination in women, and to

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educate women regarding the desirability of routine cervical cytology examinations.

The Cytology program has been a research project supported by the National Cancer Institute of the U.S. Public Health Service. Yearly grants were given for four years with the understanding that the project would terminate upon the completion of its mission.

As of December 4, 1959, a total of 50,097 patients had been examined of whom 19,756 were repeat examinations. There were 307 cases of carcinoma demonstrated of which 231 were carcinoma-in-situ. The findings will be statistically evaluated and, combined with those from six other similar pilot projects in different parts of the country, the results will be published.

The observations on the first 25,000 cases have been reported to Rhode Island physicians at an annual scientific meeting of the state medical society, and they have also been reported to the Intersociety Cytology group, and published in the December, 1959, issue of the AMERICAN JOURNAL OF OBSTETRICS AND GYNECOLOGY. An article dealing with the histopathologic studies of the cone biopsies of the cervix will be published this year in the July issue of the JOURNAL OF SURGERY, GYNECOLOGY AND OBSTETRICS.

Rhode Island physicians are urged to continue cytology examinations. Specimens will continue to be examined for a fee by the laboratory at Rhode Island hospital, and similar services are also to be available at Our Lady of Fatima, Kent County, Providence Lying-In, Miriam, Pawtucket Memorial, Newport, Westerly and Woonsocket hospitals.

Continued education of the women of Rhode Island about cytology will certainly be a commendable public health service.

A WAR OF SURVIVAL

In this issue we are privileged to report an abbreviated report on *Communicable Disease Control in Modern War,* delivered by Doctor Phair of Cincinnati at the meeting of Military Government-Civil Affairs Public Health Society last fall. Every physician will do well to read this report carefully, for it gives an informative view—frightening, to be sure—of the basic dangers that lurk in the failure to provide adequate defense against infection in the wake of a war attack.

As Doctor Phair notes in effective introduction —"Wars no longer will be decided by armies on battlefield, but, rather by the resistance of the civilian population, their will to survive and the maintenance of production in the face of attack." In this war of survival the breakdown of carefully erected peacetime safeguards would be inevitable, and a nation educated to the wonders of modern pharmaceuticals could suddenly awaken to the realization that we literally live in a sea of infection.

It is readily apparent to the reader, and certainly to the physician-reader, that the war of survival in the dreadful era that would come about if man ever loses in the quest for international peace, would be one against the control of communicable disease far more than one of missile guns and atomic-powered engines.

WHY AN AUXILIARY?

The current campaign of the Woman's Auxiliary to enroll every eligible member in the state prompts the inquiry — why an Auxiliary?

Our affiliated organization of physicians' wives has long ago demonstrated its ability to be of tremendous help in the advancement of the various programs of the state and district medical organizations, and at the same time to be able to initiate some excellent programs of its own. The nurse scholarship and recruitment plan is certainly one of the most interesting and worthwhile projects that any local club or agency could develop in the interest of the entire community.

The cultivation of friendly relations and the promotion of mutual understanding among the families of physicians is a basic reason for an auxiliary to organize, but the greater objective is seen in the role it can play as a liaison between the medical profession and the public. The socio-economic issues of today that so greatly involve medicine and public health need clear interpretation and understanding by everyone. The Auxiliary stands ready as an important agency in the dissemination of factual information to all community groups.

Thus we note with pride the work of our Auxiliary in health education matters, in national and state legislative programs, in the recruitment of students for allied medical careers, in taking a front position in civil defense and safety measures, in supporting the medical education foundation, home nursing courses, the benevolence fund of the Society — and many other fine programs that space does not permit us to delineate.

The Auxiliary is not just another woman's club — it is a live, energetic, and forceful organization that warrants the complete support of the wife of every physician in the state.

Does your wife belong?

Rhode Island Cancer Seminar . . .

April 20

See page 195

When blood pressure must come down

When you see symptoms of hypertension such as dizziness, headache, and fainting your patient is a candidate for Serpasil-Apresoline. Even when single-drug therapy fails, Serpasil-Apresoline frequently can bring blood pressure down to near-normal levels, reduce rapid heart rate, allay anxiety.

SUPPLIED: Tablets #2 (standard-strength, scored), each containing 0.2 mg. Serpasil and 50 mg. Apresoline hydrochloride; Tablets #1 (half-strength, scored), each containing 0.1 mg. Serpasil and 25 mg. Apresoline hydrochloride.

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THE WASHINGTON SCENE

A Report Issued by the Washington Office of the American Medical Association

CONGRESS APPEARS HEADED for a showdown this session on legislation for the Federal government to provide medical care for aged persons.

The medical profession and allied groups stepped up their activities in opposition to such legislation as indications mounted that the issue was approaching a crucial stage. Several state medical societies planned to send delegations to Washington to personally express their opposition to their Congressmen.

Pressure behind such legislation began to build up early in February.

The Eisenhower Administration announced it was working on three possible programs for providing health care for aged persons in cases of catastrophic — lengthy and costly — illness.

Without amplification, President Eisenhower told a news conference that there was under consideration "a possible change" in the Social Security Act "to run up the taxes by a quarter of a per cent to . . . make greater provision for the care of the aged." The President's statement that "there has been no conclusion reached in the administration" was backed up by Arthur S. Flemming, secretary of Health, Education and Welfare, in a clarifying announcement.

Flemming said his department was working on two other approaches to what he called a serious problem in addition to the possible revision of the Social Security law mentioned by Mr. Eisenhower. The H.E.W. secretary said consideration also was being given to: 1) stepped-up Federal assistance under the Federal-state public assistance program, and 2) the Federal government supplementing voluntary insurance programs.

Flemming again expressed opposition to the Forand bill which would increase Social Security taxes by one quarter of one per cent each on employers and employees to provide hospitalization, surgical benefits and nursing home care for Social Security beneficiaries. The secretary said he wanted to "underline that the position of the administration is opposition to the Forand bill."

Flemming said he hoped to have an administration bill ready to submit in early April to the House Ways and Means Committee where the Forand bill is pending. The Committee is scheduled to take up in late March or early April proposed changes to the Social Security Act.

Proponents of the Forand bill — which is vigorously opposed by the American Medical Association and allied groups — were pointing their campaign toward securing the House Committee's approval of the legislation at that time.

The AFL-CIO, a main supporter of the Forand bill, urged labor union members to write to congressmen on the Committee urging them to vote for it. The AFL-CIO also distributed a pamphlet quoting a handful of physicians as supporting the legislation. But the labor organization didn't mention that the overwhelming majority of doctors oppose it.

The Senate Subcommittee on Problems of the Aged and Aging, headed by Sen. Pat McNamara (D., Mich.), issued on behalf of its Democratic majority a report stating that use of the Social Security program "is the most efficient procedure for providing" health care for older persons.

The A.M.A. and the Subcommittee's Republican minority promptly disputed this conclusion. An A.M.A. statement issued in Chicago said:

"The American Medical Association today sharply disagreed with the recommendation of the McNamara subcommittee regarding government medicine for Social Security beneficiaries.

"Dr. Louis M. Orr, Orlando, Florida, president of the A.M.A., said:

" 'This is a politically inspired committee. Senator McNamara, Democrat from Michigan, has long supported political medicine. The fact is that at the seven subcommittee hearings held throughout the United States, observers heard little support expressed by the older citizens who attended the hearings for government medicine financed by additional taxes and administered through Social Security.' "

The Republican minority stated that testimony before the Subcommittee "proves that it is possible for elderly people to secure private insurance to provide hospitalization and surgical benefits without any intervention by public authorities."

Sen. John F. Kennedy (D., Mass.), a leading contender for the Democratic nomination for President, introduced legislation similar to the controversial Forand bill but broader in scope. The Kennedy bill would eliminate surgical benefits but would add diagnostic outpatient and home nursing services.

MILK COMMISSION REPORT — PROVIDENCE MEDICAL ASSOCIATION, 1959

CERTIFIED MILK in Providence during 1959 was obtained from the following farms: Cherry Hill Farm, North Beverly, Mass.; Hampshire Hills Farm, Wilton, N. H.; Hillside Farm, Cranston, R. I.

Through the courtesy and co-operation of the Boston Commission we have accepted their certification of one farm from Massachusetts and one from New Hampshire.

All of the herds are under State and Federal supervision and are free from Tuberculosis and Brucella abortus infections.

The Commission, six years ago, discontinued the sale of Raw Certified Milk in the Providence market to conform with the standards in most of the larger cities. The legal standard for Pasteurized Certified milk is still 500 colonies per ml. and the actual count on all samples examined by this Commission the past year was 54 colonies per ml.

Vitamin D Certified Milk is defined as whole Certified Milk rendered antirachitic by irradiation or by the addition of a concentrate and shall be of sufficient vitamin potency to show, by biological assay, a content of at least 400 U.S.P. units per quart.

The Wisconsin Alumni Research Foundation of Madison, Wisconsin, has been doing the assaying of Vitamin D from Hillside Farm and the results have been entirely satisfactory. For the coming year we shall accept the report of this test from the State Milk Inspector.

Certified Fat-free (Skim) Milk, containing not more than 0.05 per cent butter fat, and with Vitamin A added has conformed to the standards set by the American Association of Medical Milk Commissions.

During the past year the Ring Test was performed once per month on Certified Milk and all tests were negative. This is the test acceptable to this Commission for determination of the presence of Brucella Agglutinins.

Out of about 600 samples of Certified Milk we have only found three (3) samples which had a Coliform colony count above 10 per ml.

During the past year the analysis of milk samples has been performed in the laboratories of the Rhode Island Quality Milk Association, a nonprofit organization established to promote the improvement and maintenance of the standards of milk, cream and milk products. The Board of Directors of this group is selected from consumers, producers, distributors and Public Health officials. The Rhode Island Medical Society is represented by one member on the board.

Dr. James W. Armstrong our veterinarian has resigned to accept an appointment with the State of Vermont. On his recommendation, Dr. Seymour Hoffman has been appointed.

The Sanitary Inspector is appointed by the Commission to supervise the sanitary conditions at the farm and the physician is responsible for the health of the employees at the farm. Both of the men are licensed practitioners. The Veterinarian to the farm is also appointed by the Commission.

JOHN T. BARRETT, M.D., *Chairman*
REUBEN C. BATES, M.D., *Secretary*
BERTRAM H. BUXTON, JR., M.D.
HAROLD G. CALDER, M.D.
JOHN E. FARLEY, M.D.
JOHN P. GRADY, M.D.
MAURICE KAY, M.D.
HENRY E. UTTER, M.D.

MONTHLY AVERAGES OF CERTIFIED MILK FOR 1959

	CHERRY HILL H. P. HOOD			HAMPSHIRE HILLS						HILLSIDE FARM					
	Pasteurized			Pasteurized			Skimmed with Vit. A & D			Pasteurized			Skimmed with Vit. A & D		
	B.F.	T.S.	Bacteria per C.C.	B.F.	T.S.	Bacteria per C.C.	B.F.	T.S.	Bacteria per C.C.	B.F.	T.S.	Bacteria per C.C.	B.F.	T.S.	Bacteria per C.C.
January	3.8	12.86	7	4.1	13.40	22	.....	.....	.....	3.9	12.49	99	.03	8.73	23
February	3.4	12.93	8	4.1	13.32	72	.....	.....	.....	3.8	12.06	10	.04	8.58	9
March	4.0	12.92	4	4.2	13.30	22	.....	.....	.....	3.9	12.22	9	.04	8.73	13
April	4.0	12.95	12	4.4	13.69	14	.....	.....	.....	4.1	12.77	83	.04	8.65	50
May	3.8	12.60	4	4.4	12.39	71	.04	8.8	40	3.9	12.51	30	.04	8.45	67
June	3.8	12.60	33	4.5	13.70	118	.02	8.65	18	3.8	12.23	151	.04	8.43	24
July	3.9	12.79	95	4.4	13.57	42	.....	.....	.....	3.7	12.35	62	.03	8.70	124
August	4.0	12.64	78	4.1	13.06	52	.03	8.67	27	4.0	12.44	82	.....	.....	.....
September	3.9	12.67	47	4.5	13.84	330	.04	8.82	261	3.9	12.62	67	.....	.....	.....
October	4.0	12.77	27	.....	.....	.....	.04	8.88	51	3.8	12.48	56	.....	.....	.....
November	4.0	12.88	12	4.4	13.78	28	.05	9.55	22	4.1	12.34	21	.....	.....	.....
December	4.1	13.05	10	.....	.....	.....	.05	8.81	8	4.1	12.97	29	.....	.....	.....
Yearly Average	3.8	12.80	28	4.3	13.40	77	.04	8.88	61	3.9	12.45	58	.04	8.61	44

DISTRICT MEDICAL SOCIETY MEETINGS

NEWPORT COUNTY MEDICAL SOCIETY

A meeting of the Newport County Medical Society was held on Wednesday, February 3, 1960 at the Muenchinger King Hotel. At this meeting the following officers were elected to serve in 1960:

President ..... JOSE RAMOS, M.D.
Vice-President ..... DONALD FLETCHER, M.D.
2nd Vice-President ..... CHARLES SERBST, M.D.
Secretary ..... ANNIE DOROFF, M.D.
Treasurer ..... JANIS GAILITIS, M.D.
Delegates ..... PHILOMEN CIARLA, M.D.
RICHARD KNOWLES, M.D.
Counsellor ..... JOHN MALONE, M.D.
Alternate Counsellor ..... ROBERT BESTOSO, M.D.

Respectfully submitted,
ANNIE DOROFF, M.D., *Secretary*

PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providence Medical Association was held at the Rhode Island Medical Society Library on Monday, February 1, 1960. The meeting was called to order by the president, Doctor Irving A. Beck, at 8:30 P.M.

The reading of the minutes of the previous meeting was eliminated in view of the fact that a report of the meeting would be published in the RHODE ISLAND MEDICAL JOURNAL.

Doctor Beck spoke briefly of his trip to Israel and expressed his regret that he was not present at the annual meeting at which the members honored him with election as president of the Association. He called upon the members to continue their support to the new officers in the many activities of the Association during the coming year.

Presentation of Membership Certificates

Doctor Beck presented membership certificates to the physicians elected at the January meeting of the Association.

Scientific Program

Doctor Beck introduced Doctor Louis I. Kramer, of Providence, president of the New England Diabetes Association, who in turn introduced the other guest panelists as follows: Doctor Samuel B. Beaser, of Boston, Massachusetts, visiting physician and consultant to Diabetes Clinic, Beth Israel Hospital, Boston, Doctor Leo Krall, of Boston, Massachusetts, senior physician, Joslin Clinic and New England Deaconess Hospital, and Albert Renold, of Boston, Massachusetts, director, Baker Clinic Research Laboratory.

Doctor Kramer opened the discussion and gave a brief history of the successful treatment of diabetes since the discovery in insulin in 1921 by Banting and Best. The first effective oral hypoglycemic, Carbutamide, a sulfonamide, was put in use in 1955. Since then, the sulfas have been replaced by more effective and better tolerated drugs. Those currently in use are Tolbutamide, Chlorpropamide and Phenylethyl Biguanide.

Oral hypoglycemic drugs are indicated in adults who require less than 30u of insulin particularly obese mild diabetics. They are contraindicated as exclusive therapy in severe diabetics, juveniles, infections and ketosis.

Doctor Beaser stated that diabetes is not being diagnosed early enough to afford maximum protection from the progressive pancreatic atrophy which is characteristic of all diabetics. During the prodromal phase there may be a rise in renal threshold before a post prandial blood sugar rise or abnormal glucose tolerance curve becomes evident. The average adult diabetic has less than 50% beta cells remaining and since oral hypoglycemics to be used alone require greater than 70% active beta cells these drugs should not be used as initial therapy in diabetics under 40 or severe diabetics at any age. Unsuccessful early oral drug therapy may increase pancreatic damage while insulin may protect recoverable pancreatic reserve.

Since diabetes is a progressive disease all diabetics may eventually require increased insulin. All diabetics on oral hypoglycemics may eventually require insulin.

Oral drugs are not predictable and patients using them should be followed as closely as those on insulin.

Doctor Krall discussed the hypoglycemic agents currently in use with particular reference to Phenylethyl Biguanide (DBI). He stated there were no reports of liver toxicity in the literature and that no change in routine liver function tests was noted in over 170 patients. It does however have a large incidence of G. I. side effects, all of which are reversible. It does not restore glucose to glycogen and

concluded on page 208

RHODE ISLAND MEDICAL SOCIETY PHYSICIANS SERVICE

Report of the Eleventh Annual Meeting of the Corporation, January 25, 1960

THE ELEVENTH ANNUAL MEETING of the Corporation of the Rhode Island Medical Society Physicians Service was held at the Garden Room at the Sheraton-Biltmore Hotel in Providence, Rhode Island, on Monday, January 25, 1960.

The meeting was called to order by the President, Charles J. Ashworth, M.D., at 8:15 P.M.

Roll Call

Roll Call of members present was omitted since a registration had been made of those in attendance as follows:

Rocco Abbate, M.D.
Samuel Adelson, M.D.
Charles J. Ashworth, M.D.
Robert R. Baldridge, M.D.
J. Murray Beardsley, M.D.
J. Robert Bowen, M.D.
Bertram H. Buxton, Jr., M.D.
Wilfred I. Carney, M.D.
J. Austin Carroll
George W. Chaplin
Philomen P. Ciarla, M.D.
Jeremiah E. Dailey, M.D.
Harry E. Darrah, M.D.
Michael DiMaio, M.D.
James R. Donnelly
Robert W. Drew, M.D.
Frederick C. Eckel, M.D.
Peter Erinakes, M.D.
Emil E. Fachon
Charles L. Farrell, M.D.
William J. Fischer, M.D.
Henry B. Fletcher, M.D.
Ferdinand S. Forgiel, M.D.
Warren Francis, M.D.
Frank D. Fratantuono, M.D.
Henri Gauthier, M.D.
J. Merrill Gibson, M.D.
Stanley Grzebien, M.D.
Edmund T. Hackman, M.D.
John J. Hall
John C. Ham, M.D.
Arthur E. Hardy, M.D.
Robert C. Hayes, M.D.
Harry Hecker, M.D.
Walter S. Jones, M.D.
Ernest Landsteiner, M.D.
Frank J. Logler, M.D.
Earl J. Mara, M.D.
James A. McGrath, M.D.
Joseph G. McWilliams, M.D.
Francis W. Nevitt, M.D.
Arnold Porter, M.D.
Alfred L. Potter, M.D.
William A. Reid, M.D.
Ralph D. Richardson, M.D.
Francis B. Sargent, M.D.
Carl S. Sawyer, M.D.
John Shepard, II
James J. Sheridan, M.D.
Stanley D. Simon, M.D.
Robert D. Stuart

Members of Staff: John E. Farrell, Sc.D., Executive Secretary; Stanley H. Saunders, Executive Director; Edgar H. Clapp, Associate Executive Director; William E. McCabe, Legal Counsel; Arthur Hanley, Assistant Executive Director; J. Lewis Eddy, Claims Manager; George Peterson, Assistant Claims Manager, and Frank Adae, Director, Public Relations.

Members of Claims Committee: Leland W. Jones, M.D.; Charles B. Round, M.D.; Louis A. Sage, M.D.; John J. Walsh, Jr., M.D.; Malcolm Winkler, M.D.; G. Edward Crane, M.D.; Banice Feinberg, M.D.; Gary Paparo, M.D.; Richard P. Sexton, M.D., and Harold W. Williams, M.D.

Annual Report of the Treasurer

Mr. James Donnelly, treasurer, read his annual report for the year 1959, copy of which is made part of the official minutes of the meeting.

A motion was made that the report be received and placed on file. The motion was seconded and adopted.

Annual Report of the Secretary

Doctor Charles L. Farrell, secretary, read his annual report, copy of which had been distributed to each member of the Corporation in advance of the meeting and copy of which is made part of the official minutes.

A motion was made that the report of the secretary be received and placed on file. The motion was seconded and adopted.

Report of the President

Doctor Charles J. Ashworth reported briefly on the highlights of the operations of the Physicians Service programs in 1959, and he commented on current and future problems to be faced in the progress of the programs. Copy of his report is made part of the official minutes of the meeting.

Address by Doctor Donald Stubbs

The president introduced Doctor Donald Stubbs of Washington, D.C., chairman of the Board of Directors of the Blue Shield Plans, whom he had invited to address the Corporation.

Doctor Stubbs reviewed the developments of voluntary health insurance plans in the country, and he cited the expanding interest on the part of the Federal government in these programs.

He briefly reviewed the development of the Medicare Program as a movement in the direction of national government interest in the health care field.

He discussed in detail the new Federal Employee Plan to be effective July 1, 1960. He traced the development of this legislation through the Congress, and he cited that the law has more freedom of choice for the Federal employees relative to the health insurance coverage to be available than any previous legislation has allowed.

He explained the participation Blue Cross-Blue Shield Commissions in the present planning for the insurance coverage of these employees together with the optional choice of coverage through private insurance companies.

Doctor Stubbs commented briefly on H. R. 4700 (The Forand Bill) and on the public announcements by Senator Wayne Morse relative to a Con-

gressional investigation of the cost of health care for the American people.

Report of Federal Employees Benefit Programs

Doctor Ashworth reported that on January 14 information was received on the Federal Employees Benefit Program and the officers of Physicians Service were notified of this legislation by the executive director. Subsequently a meeting of the Executive Committee of the Board of Directors was called and later on January 18th, a special meeting of the Board of Directors discussed and recommended participation of Physicians Service in the federal program.

He called upon Mr. Saunders to report on the federal program. Mr. Saunders, utilizing lantern slides, reviewed the options that Physicians Service would have, the comparison of Physicians Service plan "B" surgical schedule with a uniform national indemnity program, and the major differences between such a program and the Physicians Service "B" Plan benefits. (Copy of the statistics submitted by Mr. Saunders are made part of the official minutes of the meeting.)

At the conclusion of Mr. Saunders' presentation a motion was made and seconded that the Corporation of Physicians Service participate in the Federal Employees Health Benefits Program utilizing the present Physicians Service plans with upgraded income limits as follows:

Plan "A" — From $3,600 to $4,000 for the family.
From $3,000 to $4,000 for husband and wife.
From $2,400 to $2,800 for single subscriber.

Plan "B" — From $3,300 to $4,000 for a single person.
From $4,400 to $6,000 for husband and wife.
From $5,500 to $6,000 for family.

There was general discussion of the motion. Doctor Walter Jones reviewed the changes in the Physicians Service plans in recent years and suggested a possible "C" Plan as an alternative for the Federal Employees Program.

A vote was called on the motion as originally presented. The motion was adopted.

Membership in the National Blue Shield

Doctor Ashworth recommended that the Corporation authorize the Board of Directors to seek membership in the Blue Shield Medical Care Plans Group. The motion was seconded and adopted.

Adjournment

The meeting adjourned at 11:00 P.M.

Respectfully submitted,

CHARLES L. FARRELL, M.D., *Secretary*

Annual Report of the Secretary

At the Annual Meeting of the Board of Directors of the Rhode Island Medical Society Physicians Service Corporation, held on February 4, 1959, the following were elected as officers:

Charles J. Ashworth, M.D. ..... *President*
Earl J. Mara, M.D. ..... *Vice-President*
Charles L. Farrell, M.D. ..... *Secretary*
Mr. James R. Donnelly ..... *Treasurer*

The Board elected as its representatives of the public the following: Mr. George W. Chaplin, vice-president, Industrial National Bank; Mr. John J. Hall, director of Industrial Relations, Brown & Sharpe Manufacturing Company; Mr. Robert D. Stuart, president, Blackstone Valley Gas and Electric Company, Mr. James R. Donnelly, manager of the Pawtucket Office of the Rhode Island Hospital Trust Company; Mr. J. Austin Carroll, secretary, Providence Washington Insurance Company and Professor Chelcie C. Bosland, of Brown University. The last two named directors were nominated by the Hospital Service Corporation of Rhode Island in accordance with the state statute.

Newly elected members of the Board of Directors to serve for a term of three years were as follows: Doctors Seebert J. Goldowsky, William A. Reid, and Francis B. Sargent.

The Board held five meetings during the year and its Executive Committee held two meetings. All authorized standing committees were appointed and proceeded with assigned tasks.

The most active committee continues to be the one which handles claims. Some members meet weekly to review and process the claims which cannot be handled through routine channels in the Claims Department. At regular intervals the full committee meets to handle special problems. At quarterly intervals the Consultants and the full claims committee meet together to review the operation of Physicians Service in general, and report to the Board of Directors.

New additions to the claims committee were Doctors Robert Bowen, Thomas Perry, Malcolm Winkler, and Louis Sage. The twelve members of the Claims Committee cover the fields of general practice, internal medicine, thoracic surgery, dermatology, orthopedics, and general surgery. The twelve consultants cover radiology, obstetrics, anesthesiology, pediatrics, eye-ear-nose and throat, urology, pathology, plastic surgery, ophthalmology, neuropsychiatry, surgery, medicine, and general practice.

During the year the Professional Advisory Committee met with several physicians whose claim loads seemed to indicate a misunderstanding of the operation of the Plan. In all cases an amicable and harmonious accommodation eventuated.

In June, the Board realized that utilization

continued on next page

trends suggested the question of a rate increase and it is carefully studying the situation in order to be prepared for such an eventuality. The financial aspects of the Plan will be covered in the treasurer's report.

The development of the Federal Employees Insurance coverage has created new problems and will probably require some revisions in our present philosophy and operative procedures if we are to be able to participate in this program. The Board has this problem under study at present, and will make specific recommendations in the near future.

During the past year the Board inaugurated the "B" plan which has met with a high degree of acceptance. Statistics regarding this plan are developed in the attached summary.

One of the important projects this past year has been a joint effort with Blue Cross whereby prominent leaders in the fields of industry, business, and labor were invited to tour the Blue Cross Building, see the equipment, meet the personnel and be briefed on the operations of the plans. Following the tour the guests were given dinner. A discussion period after dinner provided an opportunity for exchange of views and opinions. This program also included doctors' nurses and secretaries throughout the state, and was productive of much favorable comment and increased rapport between doctors' offices and the administrative office of Physicians Service.

Your president and secretary, accompanied by the claims director, visited all the District Medical Societies in Rhode Island in an effort to establish closer liaison with the profession. Colored slides detailing the Plan's operation and some of the technics involved in processing claims were presented.

The progressive development of Physicians Service is compared in the attached summary of statistics for the years 1958 and 1959 which is part of this report.

Respectfully submitted,
CHARLES L. FARRELL, M.D., *Secretary*

Annual Report of the Treasurer

The Rhode Island Medical Society Physicians Service Corporation has completed ten full years of prepaid medical care service for its subscribers, who number 559,000 or 70% of the eligible population of the State of Rhode Island. Income from subscribers and Invested Funds has reached an all time high of $7,170,944. an increase of $375,845. over 1958.

Surgical-Medical claims paid have spiraled upward at a much faster pace and show an increase of $725,692. over the previous year to a total of $6,980,177. Operating Costs were $18,000. — higher — Total $409,385. or 5.7% of Income.

We show a net loss for 1959 of $218,618.

Reserves were reduced to $1,539,974.

During the year we sold $100,000. U.S. Government Securities to take care of the increased claims and we expect additional selling of securities may be necessary, as this trend continues.

The Investment Account total is $2,747,779.

This is the first time we have ended a year with an operating loss and since the loss is substantial and has continued for several months, it is obvious that something must be done to correct this situation. For some time now, we have been developing a new "Experience Rating System", designed to spread the costs more evenly, and which we plan to introduce in the near future. We believe it will be fair for the subscriber and should solve our financial problem.

Respectfully submitted,
JAMES R. DONNELLY, *Treasurer*

Rhode Island Medical Society Physicians Service
Comparison of Statistics — Years 1958 and 1959

	1958	*1959*	*Increase or (Decrease)*
Subscribers	521,434	559,759	38,325
Number of Firms Buying Physicians Service	1,155	1,243	88
Number of Participating Physicians	921	937	16
Total of Claims Paid	$6,254,485	$6,980,178	$725,693
Total of Claims Paid Since Start of Plan	$32,801,859	$39,782,037	$6,980,178
Total Assets	$3,676,127	$3,580,335	($95,792)
Total Income	$6,795,099	$7,170,945	$375,846
Total Reserves	$1,780,064	$1,539,974	($240,090)
Operating Expenses	$391,415	$409,385	$17,970
Operating Expense—%	5.8%	5.7%	(0.1%)
Ratio of Claims to Income	92.0%	97.3%	5.3%
Number of Cases Paid:			
*Surgeons	84,235	91,402	7,167
*Assistants	13,026	14,340	1,314
*Anesthetists	28,623	31,689	3,066
Medical	15,923	18,486	2,563
X ray and E. K. G.	89,220	100,589	11,369
TOTAL	231,027	256,506	25,479
*Maternity Cases (included in above)	10,151	10,341	190

Comparative Balance Sheet — Years 1958 and 1959:

	1958	1959	Increase (Decrease)
Assets			
Cash in Bank and on Hand	$ 215,484.46	$ 161,569.30	($ 53,915.16)
Accounts Receivable	615,346.28	670,986.50	55,640.22
U. S. Government Bonds	2,845,296.27	2,747,779.25	(97,517.02)
TOTAL ASSETS	$3,676,127.01	$3,580,335.05	($ 95,791.96)
Liabilities			
Accounts Payable	$ 614,097.66	$ 660,701.78	$ 46,604.12
Accrued for Claims	982,280.00	1,055,531.00	73,251.00
Unearned Subscriptions	299,685.00	324,128.15	24,443.15
TOTAL LIABILITIES	$1,896,062.66	$2,040,360.93	$144,298.27
Reserves			
Reserve for Excess Losses	$ 780,064.35	$ 539,974.12	($240,090.23)
Statutory Reserve	1,000,000.00	1,000,000.00	.....
TOTAL RESERVES	$1,780,064.35	$1,539,974.12	($240,090.23)
TOTAL LIABILITIES AND RESERVES	$3,676,127.01	$3,580,335.05	($ 95,791.96)

Statement of Income and Expense

INCOME			
Received from Subscribers	$6,724,719.37	$7,094,142.86	$369,423.49
Income from Investments	70,379.67	76,801.99	6,422.32
TOTAL INCOME	$6,795,099.04	$7,170,944.85	$375,845.81
EXPENSES			
Claim Payments	$6,254,485.18	$6,980,177.98	$725,692.80
Operating Expenses	391,414.99	409,385.10	17,970.11
TOTAL EXPENSES	$6,645,900.17	$7,389,563.08	$743,662.91
GAIN OR LOSS			
Net Gain or (Loss) Charged to Reserves	$ 149,198.87	($ 218,618.23)	($367,817.10)
DISTRIBUTION OF INCOME DOLLAR			
Claims	92.0	97.3	5.3
Operating Expenses	5.8	5.7	(.1)
Reserve — Increase or (Decrease)	2.2	(3.0)	(5.2)
TOTAL	100.0	100.0	.....

HOUSE OF DELEGATES
of the
RHODE ISLAND MEDICAL SOCIETY
Report of Meeting held on January 27, 1960

A MEETING of the House of Delegates of the Rhode Island Medical Society was held at the Medical Library on Wednesday, January 27, 1960. The meeting was called to order by the president, Doctor Alfred Potter, at 8:00 P.M. The following delegates were in attendance:

Bristol County: Robert W. Drew, M.D. *Kent County:* Peter C. Erinakes, M.D.; Edmund T. Hackman, M.D. *Newport County:* (no members present). *Pawtucket District:* Ferdinand S. Forgiel, M.D.; Robert C. Hayes, M.D.; Harry Hecker, M.D.; Alexander Jaworski, M.D.; Earl F. Kelly, M.D. *Washington County:* John D. Pinto, M.D. (Alt. delegate); James McGrath, M.D. *Woonsocket District:* (no members present). *Officers of The Rims* (other than delegates): Alfred L. Potter, M.D.; Samuel Adelson, M.D.; Earl J. Mara, M.D.; Arthur E. Hardy, M.D.; J. Murray Beardsley, M.D. *State Health Department Director:* Jeremiah A. Dailey, M.D. *Immediate Past President of Rims:* Francis B. Sargent, M.D. *Providence Medical Association:* Robert R. Baldridge, M.D.; J. Robert Bowen, M.D.; Wilfred I. Carney, M.D.; Francis H. Chafee, M.D.; Harry E. Darrah, M.D.; William J. H. Fischer, Jr., M.D.; Henry B. Fletcher, M.D.; Warren W. Francis, M.D.; Frank Fratentuono, M.D.; J. Merrill Gibson, M.D.; John F. W. Gilman, M.D.; Stanley Grzebien, M.D.; John C. Ham, M.D.; Joseph G. McWilliams, M.D.; Francis W. Nevitt, M.D.; Arnold Porter, M.D.; William A. Reid, M.D.; Ralph D. Richardson, M.D.; Carl S. Sawyer, M.D.; Stanley D. Simon, M.D. *Delegates to A.M.A.:* Arthur E. Hardy, M.D.; Charles J. Ashworth, M.D.

Also present were Doctors Richard Sexton, chairman of the Committee on Veterans Affairs, Thomas McOsker, chairman of the Committee on Highway Safety, Doctor Peter Mathieu, chairman of the Committee on Social Welfare, Doctor Stanley Sprague, chairman of the Committee on Industrial Health, and John E. Farrell, Sc.D., executive secretary of the Society.

REPORT OF THE PRESIDENT

Doctor Alfred L. Potter reported on the following matters:

That the Rhode Island Bar Association had acknowledged the Society's invitation to form a liaison committee to explore possible revision of the medical examiner code, and the matter would be presented to the Executive Committee of the Bar Association.

That many replies have been received from insurance companies on the report of the Society urging elimination of the age limit for the purchase of health and accident insurance.

That a meeting of representatives of the Society, the state Hospital Association, Blue Cross, and Physicians Service had been held on November 24. The group voted to go ahead with a committee to study problems and to develop recommendations regarding the costs of health services for the people of Rhode Island.

That there was good reason to believe that Governor Del Sesto had been misinterpreted in his statements regarding support of chiropractic legislation that would allow such cultists to treat state welfare patients.

As official delegates from the Rhode Island Medical Society to the annual meetings at neighboring states, he had named the following:

Connecticut (April 26-28),
Drs. F. B. Agnelli and James G. Chapman
Massachusetts (May 17-19),
Drs. F. Fratantuono and A. E. Russell
Maine (June 19-21),
Drs. H. Hamlin and E. Sharp
N. H. and Vermont (Oct. 6-9),
Drs. S. D. Simon and S. J. P. Turco

That the Corporation of Physicians Service had met on Monday evening and had voted to raise the income limits of both the "A" and "B" plans.

Action: It was moved that the report of the president be received and placed on file. The motion was seconded and adopted.

REPORT OF THE SECRETARY

Doctor Arthur E. Hardy, secretary, read his report, copy of which had been included in the handbook sent to the delegates.

Action: It was moved that the report of the secretary be received and placed on file. The motion was seconded and adopted.

Report of the Treasurer

Doctor J. Murray Beardsley, treasurer, read the summary of his annual report for 1959, which was

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HOUSE OF DELEGATES

continued from page 192

included in the handbook to the delegates. It was moved that the report of the treasurer be received and placed on file. The motion was seconded and adopted.

Recommendations from the Council

The secretary reported that the Council makes the following recommendations:

1. That the dates of May 2 and 3, 1961 be suggested for the Annual Meeting in that year, with the provision that the Committee on Scientific Work may suggest alternate dates if reasons appear reasonable to do so.

Action: It was moved that the recommendation be adopted. The motion was seconded and passed.

2. It was recommended that the By-Laws be amended as follows:

"Article X. Section 7. Medical Defense and Grievance. The Committee on Medical Defense and Grievance shall consist of ten (10) members, in addition to the president and the secretary of the Society, *ex officio.* Initially the committee shall be appointed as follows: the president of the Society shall appoint one member in 1960 who shall serve a term of ten (10) years, and with the advice and consent of the Council he shall appoint nine (9) additional members who, at their first organizational meeting, shall draw lots to determine the length of their terms — one, for nine years; one, for eight years; one, for seven years; one, for six years; one, for five years; one, for four years; one, for three years; one, for two years, and one, for one year — and the committee shall also elect a chairman and a vice chairman to serve for annual terms. In 1961, and each year thereafter, the president of the Society shall appoint one member for a term of ten (10) years to replace the member whose term expires. The president may appoint himself, or reappoint a member whose term expires if he so desires, but all appointees to the committee must be members in good standing of the Rhode Island Medical Society. In the event that a vacancy occurs on the committee, the president of the Society, with the advice and consent of the Council, shall appoint a member to complete the unexpired term of the member whose appointment is vacated.

"The Committee shall review all cases of threatened or instituted action for malpractice against any member of the Society, and shall also investigate all complaints concerning the professional conduct of members referred to it.

"The Committee shall have authority to require the attendance of any member before it relative to unprofessional conduct, upon not less than seven (7) days written notice to the member, and failure of the member to appear before the Committee without justifiable cause shall be reported to the Council of the Society for disciplinary action. The Committee, after investigation, shall have the authority to prefer charges of unethical or unprofessional conduct against a member of the Council."

Action: It was moved that the recommendation be adopted and the By-Law submitted to the membership in the general session during the Annual Meeting of 1960. The motion was seconded and adopted.

Communications

The secretary called to the attention of the House the communication from the medical director of the State Health Department Division of Tuberculosis Control which was included in the handbook.

Action: It was moved that approval of the program reported in the communication be given by the House. The motion was seconded and adopted.

Doctor Edmund T. Hackman, Health Officer of the City of Warwick, briefly discussed the pilot program mentioned in the communication.

The motion was passed.

* * *

A communication from the Kent County Medical Society, which was included in the handbook to the delegates, was read by the secretary.

Action: It was moved that the communication be received and placed on file. The motion was seconded and adopted.

Nominees for the Physicians Service Board of Directors

The following physicians were placed in nomination for the four terms expiring on the Board of Directors of Physicians Service: Doctors W. I. Carney; W. J. H. Fischer, Jr.; R. Hager, E. T. Hackman; A. H. Jackvony; A. Porter, and E. J. Mara.

On a written ballot the following four were elected to serve three-year terms until the annual meeting of the Corporation of Physicians Service in January, 1963: Doctors W. J. H. Fischer, Jr.; E. T. Hackman; A. Porter, and E. J. Mara.

* * *

A resolution submitted by Doctor William A. Reid included in the handbook to the delegates was read by the secretary. Doctor Reid commented on the resolution.

The resolution was as follows:

"WHEREAS there has been much public discussion in recent months of the need for additional medical schools in this country, and

WHEREAS the discussion locally has created new interest in the possibility of a medical school in Rhode Island, and

WHEREAS the institutions of higher learning in this State are by their outstanding records eminently qualified to study and to report to the community on the feasibility and the advisability

of establishing a medical school in the State of Rhode Island, therefore

BE IT RESOLVED that the House of Delegates of the Rhode Island Medical Society, assembled in meeting this 27th day of January, 1960, urge these institutions of higher education to undertake a study of this question of a local medical school, and also pledge its full support to these institutions to aid them in such a study in every way possible."

Action: It was moved that the resolution be adopted. The motion was seconded and passed.

Child-School Health Committee

The president noted that the Child-School Health Committee report was included in the handbook to the delegates (copy of the report is made part of the official minutes of the meeting).

Action: It was moved that the report be received and placed on file. The motion was seconded and adopted.

Maternal Health Committee

The president noted that the Maternal Health Committee report was included in the handbook to the delegates (copy of the report is made part of the official minutes of the meeting).

Action: It was moved that the report be received and placed on file. The motion was seconded and adopted.

Cancer Committee

The president noted that the Cancer Committee report was included in the handbook to the delegates (copy of the report is made part of the official minutes of the meeting).

Action: It was moved that the report be received and placed on file. The motion was seconded and adopted.

Advisory Committee to National Foundation

The president noted that the Advisory Committee to National Foundation report was included in the handbook to the delegates (copy of the report is made part of the official minutes of the meeting).

Action: It was moved that the report be received and placed on file. The motion was seconded and adopted.

Committee on Grievance

Doctor Francis B. Sargent, chairman of the Committee on Grievance, gave an oral report on the work of his committee, stating that since May eighteen grievance complaints had been reviewed and adjudicated by the committee. He briefly discussed some of the problems involved in these grievances.

Action: It was moved that the report of the chairman of the Grievance Committee be approved. The motion was seconded and adopted.

Medical Economics

Doctor Stanley D. Simon, chairman of the Committee on Medical Economics, gave an oral report

concluded on next page

ANNUAL CANCER SEMINAR

Rhode Island Medical Society Library

Wednesday, April 20, 1960
at 2:00 P.M.

Sponsored by the Cancer Committee of the Rhode Island Medical Society

Viruses and Neoplasia

LUDWIK GROSS, M.D.
of New York, New York

Chief, Cancer Research Unit, Veterans Administration Hospital, Bronx, New York

Breast Cancer — Current Concepts of Therapy

ANDREW G. JESSIMAN, M.D.
of Boston, Massachusetts

Staff, Peter Bent Brigham Hospital, Boston, Massachusetts

Chemotherapy by Perfusion Technique

GEORGE S. RICHARDSON, M.D.
of Boston, Massachusetts

Assistant in Surgery, Massachusetts General Hospital; Clinical Associate in Surgery, Harvard Medical School

Review and Evaluation of the Present Status of Chemotherapy in Neoplasia

DAVID KARNOFSKY, M.D.
of New York, New York

Attending Physician, Memorial and James Ewing hospitals; Member, Sloan-Kettering Institute; Associate Professor of Medicine, Cornell University Medical School.

on the activities of that committee since the September meeting of the House of Delegates.

Members of the House paid tribute to the committee for its outstanding report on the Medical Care of the Aged which has received nation-wide attention.

Action: It was moved that the report of the chairman of the Medical Economics Committee be approved. The motion was seconded and adopted.

Highway Safety

The president noted that the report of the Highway Safety Committee was included in the handbook (copy of the report is made part of the official minutes of the meeting). He called upon the chairman of the Committee, Doctor Thomas McOsker, to discuss the report. At the conclusion of the discussion it was moved that:

Action: The House receive the report of the Highway Safety Committee and approve the recommendations in it. The motion was seconded and adopted.

Committee on Social Welfare

The president called upon Doctor Peter Mathieu, chairman of the Committee on Social Welfare, to discuss the report of that committee, copy of which had been submitted to the delegates in their handbook and copy of which is made part of the official minutes of this meeting.

Action: It was moved that the report of the Committee on Social Welfare together with its recommendations be adopted. The motion was seconded and adopted.

Veterans Affairs

The president noted that the report of the Committee on Veterans Affairs was included in the handbook (copy of the report is made part of the official minutes of the meeting). He called upon Doctor Richard P. Sexton to discuss the report. Doctor Sexton reviewed the highlights of the report. It was moved that copy of the report and the recommendations therein be approved. The motion was seconded and adopted.

Industrial Health Committee

Doctor Stanley Sprague, chairman of the Committee on Industrial Health, addressed the House on the problems of the Governor's Medical Advisory Committee to the Workmen's Compensation Commission. He explained in detail the limited activities that this committee was permitted to undertake for the Commission and expressed the opinion that the legislation should be reviewed to set forth the duties of this Committee. Doctor Frank Fratantuono, secretary of the Committee, also addressed the House on this subject.

Action: It was moved that the president be authorized to appoint a Committee of three members of the Society, together with the legal counsel, to draft recommendations to be submitted to the Governor of the State relative to what it considers should be the duties of the Medical Advisory Committee to the Workmen's Compensation Commission. The motion was seconded and adopted.

Miscellaneous Business

Doctor Stanley D. Simon addressed the House on the matters brought before the Corporation of the Rhode Island Medical Society Physicians Service at its annual meeting, and he expressed the opinion that the members of the Corporation, of whom the House of Delegates comprise the majority, should be fully informed in advance of all subjects on the agenda for the meeting. Other members of the House addressed the group on the same subject.

* * *

The executive secretary asked the ruling of the House relative to a press release on the major actions taken at the meeting. The House approved of a press release edited by the chairman of the Committee on Public Information, and also approved of the possible release of the reports on Highway Safety, Social Welfare, Veterans Affairs, and the resolution on a medical school in Rhode Island.

Adjournment

The meeting was adjourned at 10:10 P.M.

Respectfully submitted,

ARTHUR E. HARDY, M.D., *Secretary*

REPORTS APPROVED BY THE HOUSE OF DELEGATES

JANUARY 27, 1960

REPORT OF THE SECRETARY

The Council has held two meetings since the September session of the House of Delegates. Actions taken at these meetings include the following:

1. It voted that the interim meeting in 1960 should be nonclinical and devoted to a discussion of political and/or socioeconomic problems of medicine; that it include participation by the Auxiliary; and that it be developed by a committee consisting of the officers of the Society, the chairman of the Committee on Scientific Work and the chairman of the Committee on Medical Economics.
2. It approved of the mailing of a committee participation questionnaire to the membership.
3. It voted that the president should appoint a committee to develop a by-law revision for the establishment of the Medical Defense and Grievance Committee.
4. It approved of a communication addressed by the chairman of the Society's Committee on Mass Immunization procedures to the commanding officer of the Quonset Naval Air Station.
5. It voted that the president appoint a committee to explore the possibility of revision of the medical examiner statute of Rhode Island, in joint consultation with a committee of the Rhode Island Bar Association.
6. It authorized the trustees of the Medical Library building to proceed with proposed repairs and improvements to the building.
7. It approved of the redemption of certain treasury notes held in the investment account, and the reinvestment in a new issue paying a higher diivdend.
8. It approved the detailed financial report for 1959 as submitted by the treasurer.
9. It authorized the legal counsel of the Society to attend the A.M.A. sponsored medical-legal conference scheduled for May, 1960, as an official delegate of the Society.
10. It approved of the nominations by the president of delegates to represent the Society at the annual meetings of the state medical associations in the other New England states.
11. It approved of the appointment of Doctor Earl F. Kelly as the Society's delegate to the national Congress on Medical Licensure, and Doctor Arthur E. Hardy as the Society's delegate to the annual meeting of the New York State medical society.
12. It approved of the appointment of Doctor Earl J. Mara as the Society's official representative to attend the Blue Shield Professional Relations Conference in Chicago in February.
13. It voted that the chairman of the Medical Advisory Committee to the State Workmen's Compensation Commission should submit a report from his committee to the House of Delegates for their consideration and advice.

ARTHUR E. HARDY, M.D., *Secretary*

Report of the Treasurer

A financial statement of the Society's general operating account, including receipts and disbursements in detail during 1959, as well as the investment portfolio established with the Trust Department of the Industrial National Bank, has been reviewed by the Council and given its approval. When the journal accounts are closed on January 31, the complete financial report will then be subject to a professional audit.

The Society increased its investment holdings during 1959, utilizing unexpended funds in the contingency accounts of both the Society's and the journal's operating funds. In addition, a bequest of $1,000 was received from the estate of Doctor Fred T. Rogers to establish a book fund in his name. At the end of 1959 the Society's investments, due to the increased market value of stocks in the past year, represented a value of $82,363.

Total cash receipts from all sources amounted to $66,224.92 and expenditures totaled $58,343.63, leaving a cash balance to start 1960 of $7,424.23, more than half of which will be used immediately to pay for necessary repairs and improvements to the medical library that are currently underway.

A brief summary of the Society's 1959 financial report, without the accounts of the medical journal, is as follows:

Cash balance, Checking Account, Industrial National Bank, January 1, 1959	$11,508.86
Receipts, 1959 (Exhibit A)	66,224.92
TOTAL	$77,733.78
Investments, 1959	11,965.92
Balance, General Account	$65,767.86
Expenses, 1959 (Exhibit B)	58,343.63
Cash balance, Checking Account, Industrial National Bank, January 1, 1960	7,424.23

* * *

Total Cash and Invested Assets, January 1, 1960:	
Cash balance, Checking Account, Industrial Nat'l	$ 7,424.23

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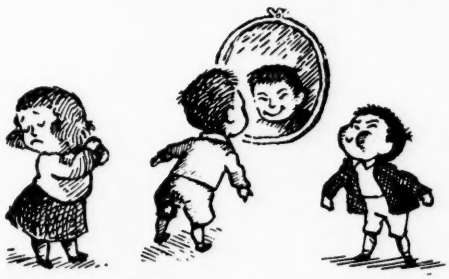
a mustache is to wear on Halloween

dogs are to kiss people



a face is something to have on the front of your head

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REPORTS APPROVED BY THE HOUSE OF DELEGATES

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Investments, Pooled Funds, Trust Department (Exhibit C), Industrial Nat'l Bank and Uninvested Principal Cash	82,363.00
TOTAL	$89,787.23

J. MURRAY BEARDSLEY, M.D., *Treasurer*

Cancer

Last year's postgraduate training program for general practitioner was so successful that it was proposed to continue the program. Several sessions shall be held this spring and next fall, covering a new group of subjects. The program is under the joint sponsorship of the Rhode Island Medical Society, Rhode Island division of the American Association of General Practitioners, and the American Cancer Society.

The subjects to be covered and the chairmen of the panels are as follows:

1. *Lung Tumors*.....THOMAS PERRY, M.D.
2. *Prostatic Cancer*.....NATHAN CHASET, M.D.
3. *Lymphomas*, WILLIAM J. H. FISCHER, JR., M.D.
4. *Skin Cancers*.....ARTHUR KERN, M.D.
5. *Cancer in Children*.....RUTH APPLETON, M.D.

The Annual Cancer Seminar will be held on Wednesday, April 20th. The program is as follows:

Viruses and Neoplasia, Dr. Ludwik Gross, Chief of Cancer Research Unit, VA Hospital, Bronx, N. Y.; *Review and Evaluation of the Present Status of Chemotherapy in Neoplasia,* Dr. David A. Karnofsky, Memorial Center for Cancer & Allied Diseases, New York City; *Chemotherapy by Perfusion Technique,* Dr. George S. Richardson, Massachusetts General Hospital; *Breast Cancer — Current Concepts of Therapy,* Dr. Andrew G. Jessiman, Peter Bent Brigham Hospital, Boston, Massachusetts.

Annual programs are planned to cover multiple facets dealing with the vanguard of cancer research, both basic and applied.

I wish to express my appreciation for the cooperation of the members of my committee, Doctors Billings, Coleman, Fletcher, Gongaware, Hardy, Rosin, Goldowsky, McDuff, McGrath, Ripley, Waterman, Webber, Murphy and Motta.

Respectfully submitted,

HERBERT FANGER, M.D., *Chairman*

Child-School Health

The Child-School Health Committee of the Rhode Island Medical Society has considered a letter from the Rhode Island Chapter of the National Association of Social Workers which requested our committee, as well as the Medical Society, endorse their efforts to encourage the use of social workers in schools throughout the state in order to recognize early emotional problems in school children. The committee was unanimously in disagreement with the philosophy as outlined by the Association of School Social Workers, but decided to meet with the Committee on Mental Health before submitting a final decision.

The Rhode Island Congress of Parents and Teachers submitted a proposal to the committee requesting approval of their plans to disseminate throughout the PTA units, recommendations regarding definite immunization schedules. It was the feeling of the committee that this was not within the scope of the League of Parents and Teachers.

The State Department of Health also requested the committee to submit an immunization schedule which would be sent out with all birth certificates. The committee disapproved this proposal unless it was to be used solely for treatment of the indigents in the state, cities and towns.

The Child-School Health Committee has no new plans for the remainder of the year except to take up any problems which may arise. We hope to help in a plan to standardize the regulations for control of contagious diseases within the state.

Respectfully submitted,

JOHN T. BARRETT, M.D., *Chairman*

Maternal Health

During the year 1959, this committee held two meetings. The first meeting was held at the home of the chairman on March 24, 1959. Besides the usual review of the maternal deaths, Doctor Buxton gave a report of the plans for formation of a perinatal committee in the state. Doctor George W. Anderson was a guest and discussed perinatal mortality studies in other sections of the country.

On September 19, 1959, a second meeting was held at the home of a new member of our committee, Dr. Herbert Ebner. Doctor George W. Corner, Jr., of Johns Hopkins Hospital was a guest and was an active participant in the discussion of the maternal deaths reviewed at this time.

A meeting of the committee will be held on January 26, 1960. At this meeting the investigation of the maternal deaths for 1959 will be completed, and we will discuss the details of preparing a confidential bulletin which will be distributed to all members of the Society. This bulletin will contain the case reports of the maternal deaths for the past year, being careful to omit names of patients, doctors, hospitals, and dates in order to insure anonymity of the cases. It is hoped that this bulletin will have educational value and help improve our obstetrics in the state. If this meets with favor, we hope to make this a yearly project.

STANLEY D. DAVIES, M.D., *Chairman*

National Foundation

The Medical Advisory Committee to the National Foundation did not have any meeting during the year 1959 as there was no business to come before this committee.

There were, however, reported ten cases of poliomyelitis in the State of Rhode Island during 1959. Six of these cases were aided by the National Foundation. There is no aid given to the nonparalytic type of cases of which there were four in Rhode Island. There was one death in Rhode Island during 1959.

We are not certain as to the percentage of immunizations by injection in our state, but I believe it is safe to say that the largest percentage, especially among the younger age group have been given at least two or possibly three injections of Salk vaccine.

To my knowledge, no research in this particular problem has been carried on in our state during 1959.

Much literature has been received and reviewed from the National Foundation and is being kept on file.

LAURENCE A. SENSEMAN, M.D., *Chairman*

Highway Safety

The Highway Safety Committee of the Rhode Island Medical Society has for years campaigned in the interest of the prevention of deaths and disabilities resulting from traffic accidents on our highways. The death toll from motor vehicle accidents is considered low in Rhode Island in comparison with other states, but such comparisons are merely statistical and there can be no comfort for anyone in the fact that in 1958 accidents were the fourth leading cause of death for all ages in our state.

The enactment of the so-called chemical test law by the General Assembly at its 1959 session was a long delayed action for which the Society had campaigned for years. The Society, through this Committee, took an active interest in the special institute held at the University of Rhode Island during the past summer for the demonstration of the use of the various procedures involved in the chemical tests to be conducted upon motorists alleged to be driving while under the influence of intoxicating liquors. Effective prosecution of test cases under this new law should be pressed as a deterrent to all persons who attempt to drive motor vehicles while under the influence of liquor or drugs.

The effective enforcement of the new motor vehicle legislation adopted at the special session should also aid in halting the death and injury toll on our highways in 1960.

Recently physicians have been criticized by police officials for not being readily available at any

continued on next page

hour of the day or night to respond to calls from a local police department to come immediately to examine an alleged drunken driver. The Society has made known its position on this question in previous years, and your Committee now recommends that the House of Delegates notify every city and town Council in Rhode Island that:

1. The Rhode Island Medical Society is deeply concerned with the problem of highway safety and the public health problem that it presents.
2. That the Society is on record as approving every effective legal action to prosecute the motorist who drives a vehicle on the highways of the state while he is under the influence of liquor or drugs.
3. That the rights of the individual be protected legally in that he continued to be permitted to be examined by a physician of his own choice, if he desires such an examination and it can be arranged.
4. That the policy adopted in Providence whereby police physicians, so called, are retained on a salary or fee basis, to be available to examine alleged drunken drivers for the police departments, be adopted in the other cities and towns.
5. That the Society pledges its full co-operation, directly and through the component district societies, to all local police authorities in securing physicians who will accept assignments as police physicians on a salary or fee for service basis, such fee to include payment for the initial examination as well as compensation for the court appearance and testimony when required.
6. That the Society urge every City and Town Council in Rhode Island to give consideration in 1960 of such a program, budgeting local funds for a proper and effective medical examination of motorists when required by a local police department, with the cost to be borne by the city or town when the motorist is exonerated, and by the motorist as part of court costs upon conviction.

* * *

Crash Safety in Auto Designs. The attention of your Committee has been directed by the Colorado State Medical Society to its efforts for the adoption of crash safety features in motor car designs. Attention is also directed to H.R. 1341, placed before the Congress in 1959, passed by the House and scheduled to come before the Senate this year.

This legislation has as its purpose "to establish reasonable safety standards for passenger-carrying motor vehicles acquired by the Federal government. The standards would be established by the Secretary of Commerce . . . ." The adoption of this regulation might materially aid in the development of safer motor vehicles for general distribution also. We urge that the Society urge our United States senators to press for passage of this act during the current session of Congress.

THOMAS C. MCOSKER, M.D., *Chairman*

Social Welfare

The Committee on Social Welfare is currently concerned with the licensure and regulation of homes for aged and convalescent persons in Rhode Island. For that reason it has met with the State Director of the Department of Social Welfare and members of his staff, and it has carefully reviewed all regulations currently imposed, and it now offers recommendations for the improvement of the care of the patients utilizing these homes.

Presently there are 161 licensed homes for aged or convalescent persons with a total of 2,229 beds. Undoubtedly there will be an increase in the number of these homes in the coming months and years. In the opinion of this Committee every effort should be directed toward maintaining the highest standards in the operation and maintenance of such homes with particular emphasis on medical care and supervision.

Your Committee commends the Department of Social Welfare for its effective work in maintaining standards in the homes for which it issues

licenses, and it believes that additional staff personnel should be employed to aid in the work of visiting and checking the operation of the homes periodically.

The present regulations of the Department in the opinion of the Committee do not clearly indicate that more than one person should be in attendance in the home in a responsible capacity at all times. The regulations merely state that a registered nurse or practical nurse shall be on duty at specified hours. The registered nurse coverage requirement is on the basis of a minimum of forty hours weekly, but there are a few small homes that were classified as nursing homes prior to the establishment of the R.N. requirement for whom the rule is waived. However the Department records that in no instance has such a home been approved without recommendation of a physician who vouched for the ability of the applicant. Since December, 1954, all new nursing homes have been required to provide the forty-hour-per-week registered nurse care during the day, with the balance of the twenty-four hour period being covered by a licensed practical nurse.

According to the Department 88 registered nurses are now employed in the nursing homes, including owners and staff nurses living on the premises, who cover more than one shift. Of this number 24 are owners, and on call at practically all hours. Sixteen are employed on night shifts, and the balance on days.

This Committee is of the opinion that there should be a designated aide or attendant, or person otherwise responsible, available at all times in the event the registered nurse or the practical nurse is occupied when an emergency might arise. Such authorized aide or attendant should be properly designated for the information of all patients in the respective home.

SPECIAL REGULATIONS. The Committee has considered Regulation 10 which reads:

> Adequate sleeping quarters must be provided and no more than two patients may occupy any one room. Each semi-private room must have a minimum area of 160 square feet.

The Department justifies this rule with the understanding that the long-term patient who has little prospect of returning to his or her own home has every right to live in as homelike an atmosphere as is possible. Therefore the limitation of two to a room is provided in the belief that two persons can be expected to adjust to each other's idiosyncrasies, but that more than two in a room can cause an older person, denied reasonable privacy and opportunity for self-expression, to withdraw from his or her surroundings much as does a child.

The Committee concurs with this reasoning as justifying the regulation.

Regulation 11 reads as follows:

> The rooms shall be well ventilated and lighted, with a minimum of two windows in a semi-private room.

This regulation has been in effect for more than twenty years according to the Department. It is interpreted by the present staff of the Department to mean an area providing light and ventilation ordinarily provided by the average window. In some few instances where an existing window is found to have twice the area of an average window the room has been approved as having the equivalent of two windows.

The Committee recommends that this regulation be reviewed in the light of modern lighting and ventilation systems and architecture, and that it be rewritten accordingly without lessening the objective sought for a standard of comfort and health of the patients.

Regulation 5 stipulates that —

> No licensee will be issued a license to operate, or to participate in, the concurrent operation of more than one home for aged or convalescent persons, nor will favorable consideration be given any applicant who operates such a home in another state.

In justification of this rule the Department maintains that some years ago it became apparent that when more than one home was operated by an individual, one or both suffered from poor administration, being, to a considerable degree controlled by personnel who were not directly responsible to the Department or who assumed little or no responsibility for high standards of care. The Department believes this regulation has resulted in higher standards and at the same time has effectively prevented monopoly which has proven to be a serious problem in other states. The Department maintains that small homes meet a definite need in our state, and if it were not so restrictive it believes that a large syndicate might be expected to force small facilities out of business in a comparatively short time.

Your committee cannot agree with this reasoning. In the first instance the Department is authorized to license homes that meet high standards for the care of the patients to be housed. Each home to be licensed is judged on its individual merits as regards its adequacy of the purpose intended, the qualifications of its personnel, etc. The ability of one or more such licensees to maintain an approved establishment in more than one community should not be a deterrent to the licensure of the second approved home. In our opinion the question is not one of ownership, once the applicant is fully approved and qualified as a responsible person, but one of maintaining a high standard of service and supervision in each individual home.

concluded on next page

Your Committee believes this regulation should be eliminated. We further recommend that the State Department of Social Welfare give consideration to the proposal that a doctor of medicine be employed, not necessarily on a full time basis, to supervise the medical provisions of the licensure regulations, with particular regard to the individual medical and health care of the persons housed in all aged and convalescent homes.

STANDARD ORDERS FOR NURSES. We also recommend that Standing Orders, similar to those approved for nurses engaged in industrial health work, be adopted for the nurses in the licensed homes. To this end the Committee submits as part of this report a suggested draft of such Standing Orders (Appendix A).

GUIDES FOR MEDICAL CARE IN LICENSED HOMES. The Committee on Medical Facilities of the Council on Medical Service of the American Medical Association has been engaged for some time in a study of the activities in the field of nursing homes. In its report to the House of Delegates of the American Medical Association, at Dallas, Texas (December 1-4, 1959), it noted that one of the great needs is improvement in the standards of the nation's nursing homes.

As a service to these facilities, their parents, and the physician caring for these patients, guides for medical care in nursing homes and related facilities have been developed. These guides, drafted by the liaison committee of the American Medical Association and the American Nursing Home Association, are appended to and made part of this report (Appendix B).

Your Committee recommends the adoption of these guides for use by the Department of Social Welfare in Rhode Island, with the co-operation and assistance of the Society.

DIET GUIDES. The Committee recommends that the *Rhode Island Normal and Therapeutic Diet Guide* written in 1951 by a diet therapy committee, and approved by the Rhode Island Medical Society, the State Health Department, and the Rhode Island Dietetic Association, be revised and published. Distribution of this guide should be made to every physician in the state, and also to the supervisor of every licensed home.

PHYSICIAN INTEREST. The Committee is in agreement that the private physicians throughout the state should be urged to maintain a more active interest in the medical supervision of the homes, and the medical care rendered to patients in them. We recommend that the Society direct a message to the entire membership calling attention to the fact that medical care in homes for the aged and convalescents should have the maximum medical supervision by physicians in the local areas, and that local county and district medical associations should undertake to check on all persons, and particularly the aged, residing in the facilities in their areas. We particularly emphasize the importance of the patient having the attention of his or her own private physician at all times. Attention of all physicians should also be directed to the Guides for Medical Care in Nursing Homes and Related Facilities, to which reference is made above (Appendix B).

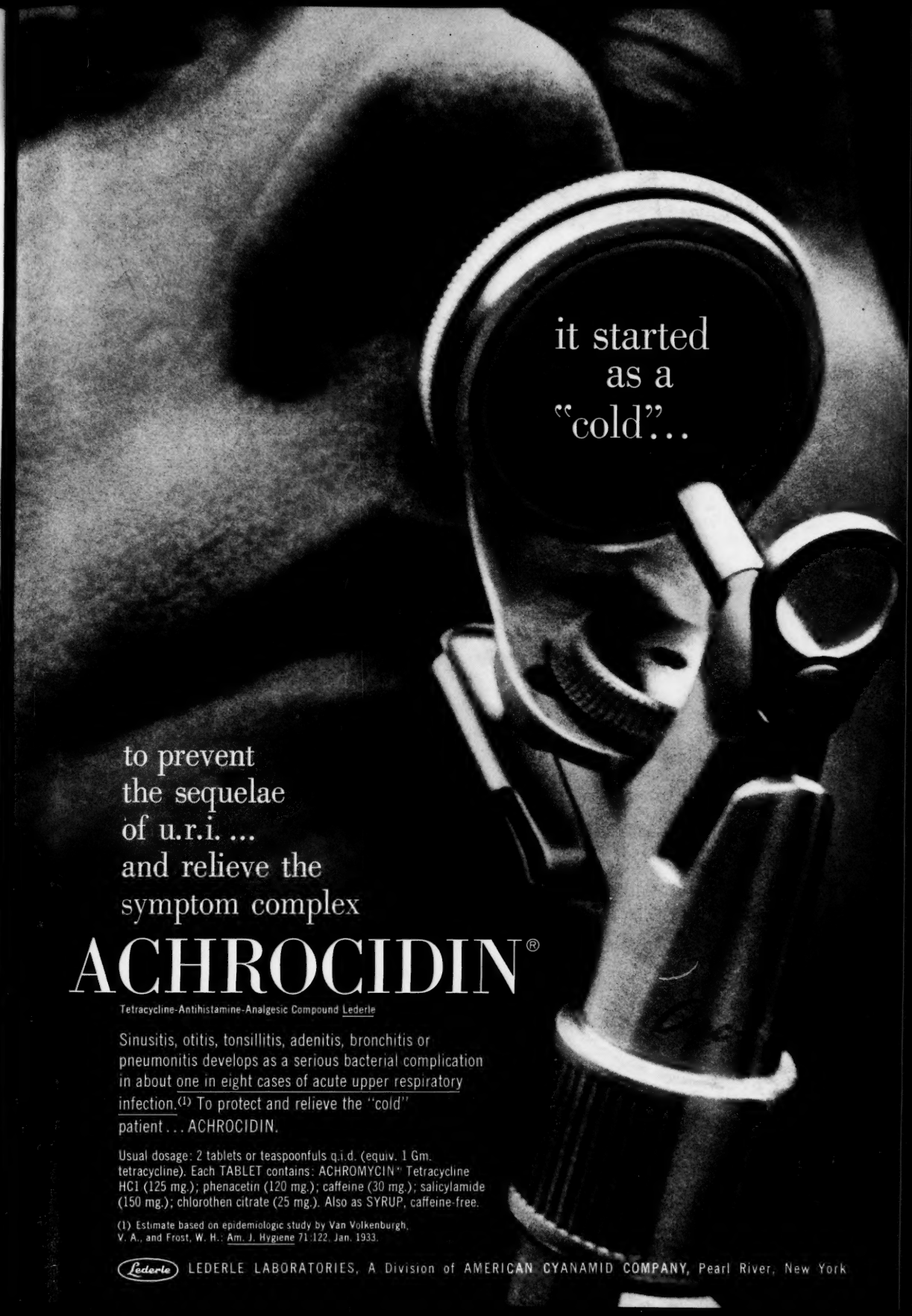
* * *

This Committee recommends that the Department of Social Welfare give careful consideration to the recommendations stated in this report, and further, that it have periodic checks conducted of each licensed home, and that it submit reports regularly to the Committee on Social Welfare of the Rhode Island Medical Society in order that the Society may assist the Department in any of its problems involving medical treatment and care of all persons residing in aged, or convalescent homes.

Respectfully submitted,

PETER MATHIEU, M.D., *Chairman*

APPENDICES A and B of this report will be published in the April issue of the *Journal*.



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of u.r.i. ...
and relieve the
symptom complex

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Usual dosage: 2 tablets or teaspoonfuls q.i.d. (equiv. 1 Gm. tetracycline). Each TABLET contains: ACHROMYCIN® Tetracycline HCl (125 mg.); phenacetin (120 mg.); caffeine (30 mg.); salicylamide (150 mg.); chlorothen citrate (25 mg.). Also as SYRUP, caffeine-free.

(1) Estimate based on epidemiologic study by Van Volkenburgh, V. A., and Frost, W. H.: Am. J. Hygiene 71:122, Jan. 1933.

Lederle LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

PROVISIONAL VITAL STATISTICS, 1959
RHODE ISLAND DEPARTMENT OF HEALTH

PROVISIONAL VITAL STATISTICS for 1959 are available from vital records filed currently during the twelve-month period. The data for 1958 are given also to obtain an indication of trends; these data are not strictly comparable, since the 1958 data include events filed through March 20, 1959. This report gives the provisional numbers for events that occurred in Rhode Island regardless of the place of residence. The final report will give data for Rhode Island residents regardless of place of occurrence and will include certificates received through March 20, 1960.

Births

There were 19,283 live births recorded during 1959 representing an increase of 2 per cent over last year's total. The crude birth rate of 22.0 per 1,000 population was practically the same as the rate of 21.9 obtained for 1958.

Marriages

The number of marriages recorded increased by 1.7 per cent and the rate by 1.5 per cent in 1959 from their levels in 1958. In 1959 there were 5,753 marriages recorded compared with 5,659 last year. The 1959 and 1958 rates per 1,000 population were 6.6 and 6.5, respectively.

Deaths

The death rate for 1959 was 10.0 per 1,000 population, about 3 per cent below the rate of 10.3 obtained in 1958. The number of deaths recorded in 1959 (8,753) was 120 less than in 1958 (8,873).

In 1959 there were 447 deaths of babies under one year of age; this is an increase of 40 or almost 10 per cent when compared with 1958 (407). The infant mortality rate (23.2 per 1,000 live births) increased by approximately 8 per cent over the 1958 rate of 21.5.

Slightly more than three-fourths (76.1 per cent) of the infant deaths occurred during the first 28 days of life. There were 340 neonatal deaths in 1959, representing an increase of 10 per cent over the 308 neonatal deaths in 1958. The 1959 rate (17.6 per 1,000 live births) increased by 8 per cent over the rate of 16.3 obtained in 1958.

A slight improvement is noted in the maternal death rate for 1959, 2.1 per 10,000 live births when compared with 2.6 in 1958. There was 1 less maternal death during the past year than in 1958 (5 in 1958 and 4 in 1959).

Fetal Deaths

In 1959 fetal deaths, which are not included in total deaths, numbered 430 compared to 291 fetal deaths (stillbirths) reported in 1958; this is nearly a 50 per cent increase between the two years. The rate rose markedly from 15.4 per 1,000 live births in 1958 to 22.3 in 1959. The increased fetal death rate in 1959 is believed to be due almost wholly to 1) the lowering of the gestation period mentioned below and 2) improved reporting.

Fetal death rules and regulations were revised effective April 1, 1959. These revisions were made in co-operation with the Perinatal Mortality Committee of the Rhode Island Medical Society. This committee has stimulated interest in these events among obstetricians. The *required* period for reporting was shortened from six months gestation to include any product of 20 weeks or more gestation. All products of gestation are *requested* to be reported, as has been the practice in the past.

Principal Causes of Death

The ten leading causes of death accounted for seven eighths of the total deaths in 1959. The rank order of the first four causes was the same for 1958 and 1959. Diseases of the heart, which headed the list, killed 138 more people in 1959 than in 1958. There were fewer deaths from malignant neoplasms and vascular lesions in 1959. An increase was noted in the mortality rate from motor-vehicle

TABLE I
Vital Statistics: Rhode Island, 1958 and 1959

Item	*Number*			*Rate*		
	1959	*1958*	*Percent Change*	*1959*	*1958*	*Percent Change*
Live Births*	19,283	18,911	+2.0	22.0	21.9	+0.5
Marriages*	5,753	5,659	+1.7	6.6	6.5	+1.5
Deaths*	8,753	8,873	—1.4	10.0	10.3	—2.9
Infant Deaths**	447	407	+9.8	23.2	21.5	+7.9
Neonatal Deaths**	340	308	+10.4	17.6	16.3	+8.0
Fetal Deaths**	430	291	+47.8	22.3	15.4	+44.8

*Rate per 1,000 population
**Rate per 1,000 live births

accidents.

Certain diseases of early infancy jumped from 6th place in 1958 to 5th place in 1959; influenza and pneumonia dropped from 5th place in 1958 to 7th in 1959. Congenital malformations ranked 9th among the leading causes in 1959, but was not in-

continued on next page

TABLE II

Deaths and Death Rates per 100,000 Population from Ten Principal Causes of Death: Rhode Island, 1958 and 1959

Causes of Death	*1959*		*1958*	
	Number	*Rate*	*Number*	*Rate*
1. Diseases of the heart	3,926	448.7	3,788	437.9
2. Malignant neoplasms	1,551	177.3	1,585	183.2
3. Vascular lesions	855	97.7	911	105.3
4. Accidents	307	35.1	301	34.8
5. Diseases of early infancy	272	31.1	251	29.0
6. Diabetes mellitus	219	25.0	233	26.9
7. Influenza and pneumonia	189	21.6	259	29.9
8. Cirrhosis of liver	121	13.8	132	15.3
9. Congenital malformations	114	13.0	96	11.1
10. Other diseases of circulatory system	111	12.7	106	12.3

TABLE III

Provisional Numbers of Deaths from Selected Causes: Rhode Island, 1958 and 1959
(Excludes fetal deaths; Rates per 100,000 estimated population except as noted)

Cause of Death (Seventh Revision of the International Lists, 1955)	*1959*		*1958*	
	Number	*Rate*	*Number*	*Rate*
All Causes#	8,753	10.0	8,873	10.3
Tuberculosis, all forms (001-019)	52	5.9	41	4.7
Syphilis & its sequelae (020-029)	13	1.5	10	1.2
Typhoid fever (040)	.....	.....	.....	.....
Dysentery, all forms (045-048)	5	0.6	.....	.....
Scarlet fever & streptococcal sore throat (050, 051)	3	0.3	.....	.....
Diphtheria (055)	.....	.....	.....	.....
Whooping cough (056)	1	0.1	.....	.....
Meningococcal infections (057)	1	0.1	5	0.6
Acute poliomyelitis (080)	1	0.1	.....	.....
Encephalitis (082)	1	0.1	3	0.3
Measles (085)	.....	.....	4	0.5
Infectious hepatitis (092)	6	0.7	3	0.3
Malignant neoplasms (140-205)	1,551	177.3	1,585	183.2
Diabetes mellitus (260)	219	25.0	233	26.9
Meningitis, except meningococcal & tuberculous (340)	7	0.8	9	1.0
Cardiovascular-renal dis. (330-334, 400-468, 592-594)	5,124	585.6	5,083	587.6
Vascular lesions (330-334)	855	97.7	911	105.3
Rheumatic fever (400-402)	2	0.2	5	0.6
Diseases of heart (410-443)	3,926	448.7	3,788	437.9
Hypertension without mention of heart (444-447)	74	8.5	73	8.4
General arteriosclerosis (450)	110	12.6	134	15.5
Other diseases of circulatory system (451-468)	111	12.7	106	12.3
Chronic & unspecified nephritis (592-594)	46	5.3	66	7.6
Influenza (480-483)	3	0.3	5	0.6
Pneumonia (490-493)	186	21.3	254	29.4
Bronchitis (500-502)	33	3.8	46	5.3
Ulcer of stomach & duodenum (540, 541)	72	8.2	80	9.2
Appendicitis (550-553)	6	0.7	8	0.9
Hernia & intestinal obstruction (560, 561, 570)	63	7.2	61	7.1
Gastritis, enteritis, etc. (543, 571, 572)	38	4.3	31	3.6
Cirrhosis of liver (581)	121	13.8	132	15.3
Acute nephritis & nephrosis (590, 591)	7	0.8	7	0.8
Hyperplasia of prostate (610)	17	1.9	27	3.1
Complications of pregnancy, childbirth, etc.* (640-689)	4	2.1	5	2.6
Congenital malformations (750-759)	114	13.0	96	11.1
Certain diseases of early infancy (760-776)	272	31.1	251	29.0
Symptoms, senility & ill-defined conditions (780-795)	15	1.7	14	1.6
Accidents (800-962)	307	35.1	301	34.8
Motor-vehicle accidents (810-835)	91	10.4	77	8.9
All other accidents (800-802, 840-962)	216	24.7	224	25.9
Suicide (963, 970-979)	58	6.6	42	4.9
Homicide (964, 980-985)	12	1.4	6	0.7

#Rate per 1,000 population
*Rate per 10,000 live births

cluded in the 1958 list of ten principal causes of deaths.

Table II shows the number of deaths with rates per 100,000 population for the ten principal causes of deaths in 1959 and for these same causes in 1958.

Population estimates are provided by the United States Bureau of the Census in "Current Population Reports" Series P-25, Numbers 208 and 210. The revised 1958 estimate is 865,000 and the provisional 1959 figure is 875,000 for the State of Rhode Island.

In Table III are shown the provisional numbers of deaths from selected causes with rates for 1958 and 1959. (A more detailed breakdown of causes of death is available upon request.)

PROVIDENCE MEDICAL ASSOCIATION

concluded from page 186

does not lower blood sugar in non-diabetics. He advised starting at low dosage and cutting back quickly if G. I. Symptoms become evident. Some difficult to control diabetics may be better handled with DBI and insulin than insulin alone.

Doctor Renold, utilizing lantern slides, discussed the mechanism of action of various oral hypoglycemic agents. The exact mechanism is not known but the sulfonyl ureas seem to stimulate the release of hypoglycemic agent from the pancreas, increase the plasma insulin activity and decrease the production of ketone bodies in the liver. For DBI it is postulated that an inhibition of certain oxidative enzymes occurs (interruption of the Krebs cycle). He closed by mentioning some of the newer drugs having hypoglycemic activity which are currently under investigation.

The meeting was adjourned at 10:30 P.M.

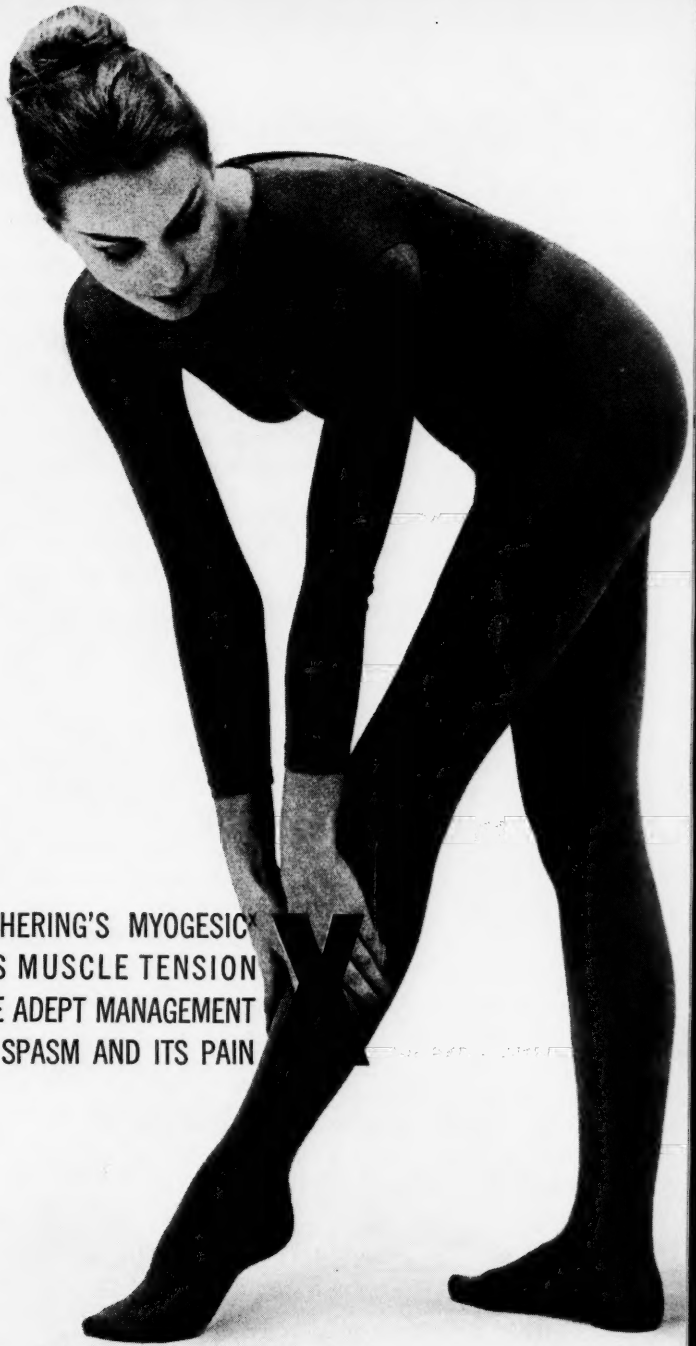
Attendance was 96.

Collation was served.

Respectfully submitted,

WILLIAM A. REID, M.D., *Secretary*

INDEX OF ADVERTISERS



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OF BOTH SPASM AND ITS PAIN

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PROGRAM OF THE 149th ANNUAL MEETING
THE RHODE ISLAND MEDICAL SOCIETY

May 10 and 11, 1960 — *At the Rhode Island Medical Society Library*

TUESDAY, MAY 10

7:00 P.M. REGISTRATION AND TOUR OF TECHNICAL EXHIBITS

8:15 P.M. CALL TO ORDER

Presiding: ALFRED L. POTTER, M.D.
(President, Rhode Island Medical Society)

8:30 P.M. "DIRECT VISUAL APPROACH TO ACQUIRED VALVULAR HEART DISEASE IN ADULTS"

J. GORDON SCANNELL, M.D.

(Assistant Clinical Professor of Surgery, Harvard Medical School; Associate Visiting Surgeon, Massachusetts General Hospital)

9:00 P.M. "ANTIBACTERIAL AGENTS: USES AND ABUSES IN TREATMENT AND PROPHYLAXIS"

(Charles V. Chapin Oration)

MAXWELL FINLAND, M.D.

(Associate Professor of Medicine, Harvard Medical School; Associate Director, Thorndike Memorial Laboratory, and Physician-in-Chief, Fourth Medical Service, Boston City Hospital)

10:00 P.M. ADJOURNMENT. TOUR OF TECHNICAL EXHIBITS

WEDNESDAY, MAY 11

10:00 A.M. REGISTRATION. TOUR OF TECHNICAL EXHIBITS

11:00 A.M. CALL TO ORDER

Presiding: SAMUEL ADELSON, M.D.
(Vice President, Rhode Island Medical Society)

11:00 A.M. to 12:00 NOON PANEL ON BACK PAIN

Moderator: KENNETH G. BURTON, M.D.

(Surgeon-in-Chief, Department of Fractures and Orthopedics, Rhode Island Hospital)

"GYNECOLOGICAL CAUSES OF BACK ACHE"

HENRY C. MCDUFF, JR., M.D.

(Chief, Department of Gynecology, Rhode Island Hospital)

"BACK ACHE FROM THE ORTHOPEDIC POINT OF VIEW"

A. A. SAVASTANO, M.D.

(Orthopedic Surgeon, Miriam Hospital; Associate Orthopedic Surgeon, Rhode Island Hospital)

"GENITOURINARY CAUSES OF BACK ACHE"

ERNEST K. LANDSTEINER, M.D.

(Surgeon-in-Chief, Urological Service, Rhode Island Hospital)

"AS SEEN BY THE INTERNIST"

DANIEL G. CALENDA, M.D.

(Assistant Physician, Department of Medicine, Rhode Island Hospital)

12:00 NOON "REPORT OF AN ORTHOPEDIC SURVEY OF 5,000 ISRAELI CHILDREN"

HYMAN GOLDMAN, M.D.

(Head, Orthopedic Department, Poriah Government Hospital, Israel)

12:30 P.M. INTERMISSION. Buffet luncheon in basement dining room. Advance reservation required for lunch.

TOUR OF TECHNICAL EXHIBITS

1:45 P.M. CALL TO ORDER

Presiding: EARL J. MARA, M.D.

(President-elect, Rhode Island Medical Society)

Recognition of Delegates from State Medical Societies

2:00 P.M. "FOREIGN MEDICAL GRADUATES SERVICE AS INTERNS OR RESIDENTS IN UNITED STATES HOSPITALS"

DEAN F. SMILEY, M.D.

(Executive Director, Educational Council for Foreign Medical Graduates)

2:30 P.M. "BASIC REQUISITES FOR AN ADEQUATE COMPENSATION SYSTEM"

ALEX P. AITKEN, M.D.

(Professor, Orthopedic Surgery, Tufts University School of Medicine; Surgeon-in-Chief, Orthopedic Surgery, Boston City Hospital)

3:00 P.M. "A NEW APPROACH TO TREATMENT OF CARDIAC AND HEPATIC EDEMA BY STEROIDS"

HARRY GOLD, M.D.

(Professor of Clinical Pharmacology, Cornell University Medical College; Attending-in-charge of the Cardiovascular Research Unit, Beth Israel Hospital; Attending Cardiologist, Hospital for Joint Diseases)

INTERMISSION TO VISIT TECHNICAL EXHIBITS

4:00 P.M. "THE PULMONARY MICROCIRCULATION"

JOHN IRWIN, M.D.

(Director of Microcirculatory Laboratory, Massachusetts Eye and Ear Infirmary; Assistant in Medicine, Massachusetts General Hospital; Research Associate, Massachusetts Institute of Technology)

4:30 P.M. PRESIDENTIAL ADDRESS

ALFRED L. POTTER, M.D.

(President, Rhode Island Medical Society)

5:00 P.M. GENERAL SESSION OF THE RHODE ISLAND MEDICAL SOCIETY

(Installation of officers for 1960-1961)

EVENING SESSION

6:00-7:00 P.M. RECEPTION. Sheraton-Biltmore Hotel

(For members of the Society and guests)

7:00 P.M. ANNUAL DINNER. Ballroom, Sheraton-Biltmore Hotel

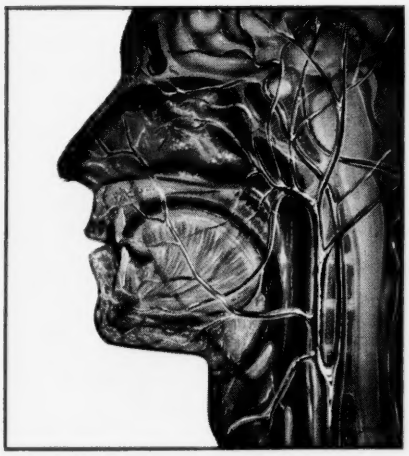
Presidential Award

9:00 P.M. ADDRESS

"SCOTCH HUMOR OR YANKEE WISDOM"

DR. JOHN NICOL MARK

reaches all nasal and paranasal membranes *systemically*[1]



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- in allergic reactions of the upper respiratory tract

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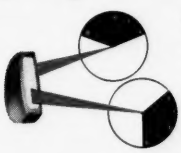

first — the outer layer dissolves within minutes to produce 3 to 4 hours of relief

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Each Triaminic timed-release Tablet provides:
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Dosage: 1 tablet in the morning, midafternoon and at bedtime. In postnasal drip, 1 tablet at bedtime is usually sufficient.

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Dosage: 1 Juvelet in the morning, midafternoon and at bedtime.

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Dosage (to be administered every 3 or 4 hours): *Adults* — 1 or 2 tsp.; *Children 6 to 12* — 1 tsp.; *Children 1 to 6* — ½ tsp.; *Children under 1* — ¼ tsp.

1. Fabricant, N. D.: E.E.N.T. Monthly *37*:460 (July) 1958.
2. Lhotka, F. M.: Illinois M. J.: *112*:259 (Dec.) 1957.
3. Farmer, D. F.: Clin. Med. *5*:1183 (Sept.) 1958.

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THE WASHINGTON SCENE

A Summary Report from the Washington Office of the American Medical Association

CONGRESS HAS BEEN WARNED against acting on legislation to provide health care of the aged before receiving the recommendations of next year's White House Conference on Aging.

Rep. Noah M. Mason (R., Ill.), ranking minority member of the House Ways and Means Committee which handles such legislation, put in the Congressional Record an exchange of correspondence with former Rep. Robert W. Kean (R., N. J.), chairman of the National Advisory Committee supervising preparations for the White House Conference next January.

Rep. Mason said the correspondence "reveals the reason why Congress should await the results of the Conference."

"Let us not waste the $2 million we have already appropriated to bring thousands of good minds together to suggest solutions to problems of our aging population," Rep. Mason said. "Certainly we should get the benefit of their advice rather than enact legislation in haste and without proper study."

Doctor F. J. L. Blasingame, executive vice president of the American Medical Association, also voiced this warning in a radio interview while he was in Washington for conferences with White House aides and Arthur S. Flemming, secretary of Health, Education and Welfare.

Doctor Blasingame said that it would be "neither practical nor realistic" for Congress to act on such legislation until the White House Conference and other sources had compiled "more conclusive and complete information" on a nationwide basis.

Doctor Blasingame and other A.M.A. representatives emphasized to President Eisenhower's aides and Flemming that the medical profession is unalterably opposed to any legislation, such as the Forand bill, that would use the Social Security system to provide health care for the aged.

In his letter to Mason, Kean predicted that "in all probability" most of the White House Conference's recommendations would be for "state and local activity" in dealing with the problems of the aged. Kean said that action at the state and local level "seems most effective."

The National Association of Manufacturers charged in a pamphlet that supporters of Forand-type legislation have exaggerated the health care needs of the nation's older people. The NAM pamphlet also said the Forand bill was an entering wedge for a cradle-to-grave compulsory health insurance plan.

Meantime, supporters of the Forand bill — particularly the AFL-CIO, continued an intensive pressure campaign aimed at Congressional approval of the legislation in this national election year when Congressmen are more susceptible to such pressure.

Another Democratic presidential hopeful, Sen. Hubert H. Humphrey (D., Minn.), reiterated his support for Forand-type legislation. He proposed a six-point program for aid for the elderly, including "an extension of the Social Security system to cover the cost of hospital and nursing home care for senior citizens."

Sen. John F. Kennedy (D., Mass.), a leading contender for the Democratic nomination for President, has introduced similar, but even broader, legislation.

Elsewhere on the national legislative front, prospects brightened for Congressional passage this year of a bill to permit physicians and other self-employed persons to set aside money for retirement.

The Administration, which last year opposed a bill with such provisions, appeared in mid-March to be ready to support it with modifications.

The Administration shift improved the already favorable odds that both the Senate Finance Committee, where a House-approved bill was pending, and the Senate would approve such legislation this session.

* * *

The issue of generic names vs. trade names in doctors' prescriptions came to the forefront in the Senate Monopoly Subcommittee's investigation of the drug industry.

Doctor Austin Smith, president of the Pharmaceutical Manufacturers Association, testified at a subcommittee hearing that "behind brand names lie the reputation, reliability and skill of the manufacturer." He said use of generic terms would restrict a physician's choice as to drugs and would transfer some of the physician's responsibility to the pharmacist.

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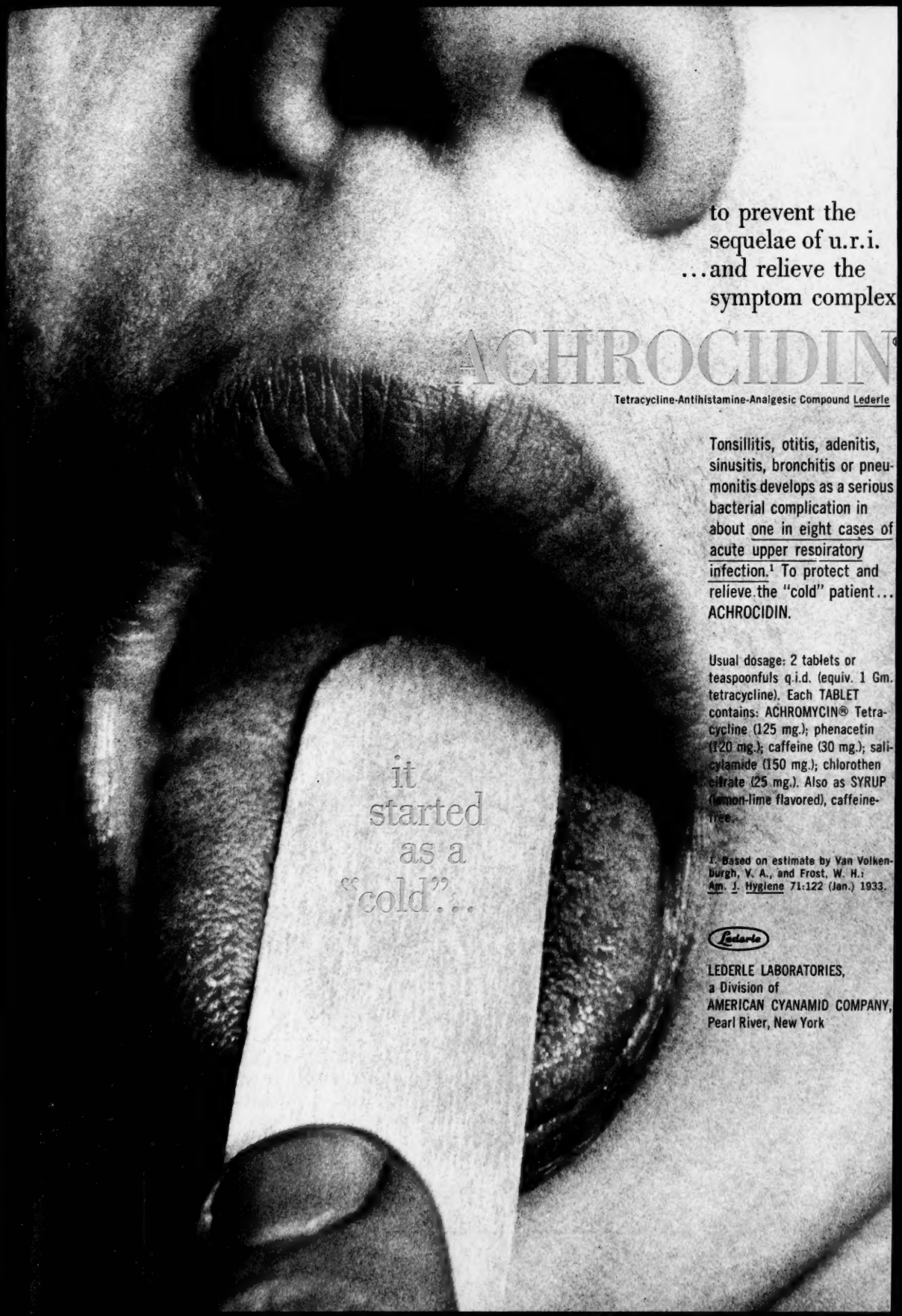

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1. Based on estimate by Van Volkenburgh, V. A., and Frost, W. H.: Am. J. Hygiene 71:122 (Jan.) 1933.

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"By brand name prescription, the doctor orders for a patient a specific product in which he has absolute knowledge of quality, purity and any side effects that might have importance for a particular patient," Doctor Smith said.

Doctor R. B. Robins of Camden, Ark., who accompanied Smith at the hearing, submitted a similar statement. He said he used trade names because: "It is simpler to write such a prescription and I can be assured that no substitution will be made by the druggist—this assures me that the patient will get top quality."

Doctor Robins appeared before the subcommittee as a private practicing physician and not in his capacity as a member of the A.M.A. Board of Trustees.

Despite this testimony, Sen. Estes Kefauver (D., Tenn.), the chairman of the subcommittee, said he hoped physicians would give "serious thought" to use of generic terms. He contended that doctors thus could bring down drug prices by opening the way for small manufacturers to give the major companies "some good, honest, old-fashioned price competition."

* * *

President Eisenhower's Conference on Occupational Safety urged stronger X-ray legislation by the states with an aim of protecting consumers and workers against too much radiation.

The three-day Conference also said there is need "for effective educational programs to reduce both consumer and occupational exposures to X rays used for diagnosis and therapy, X-ray installations in industry for product control and related purposes and various X-ray devices, such as shoe-fitting fluoroscopes."

The Conference also recommended intensive efforts to develop better ways of determining safe exposure levels of radiation.